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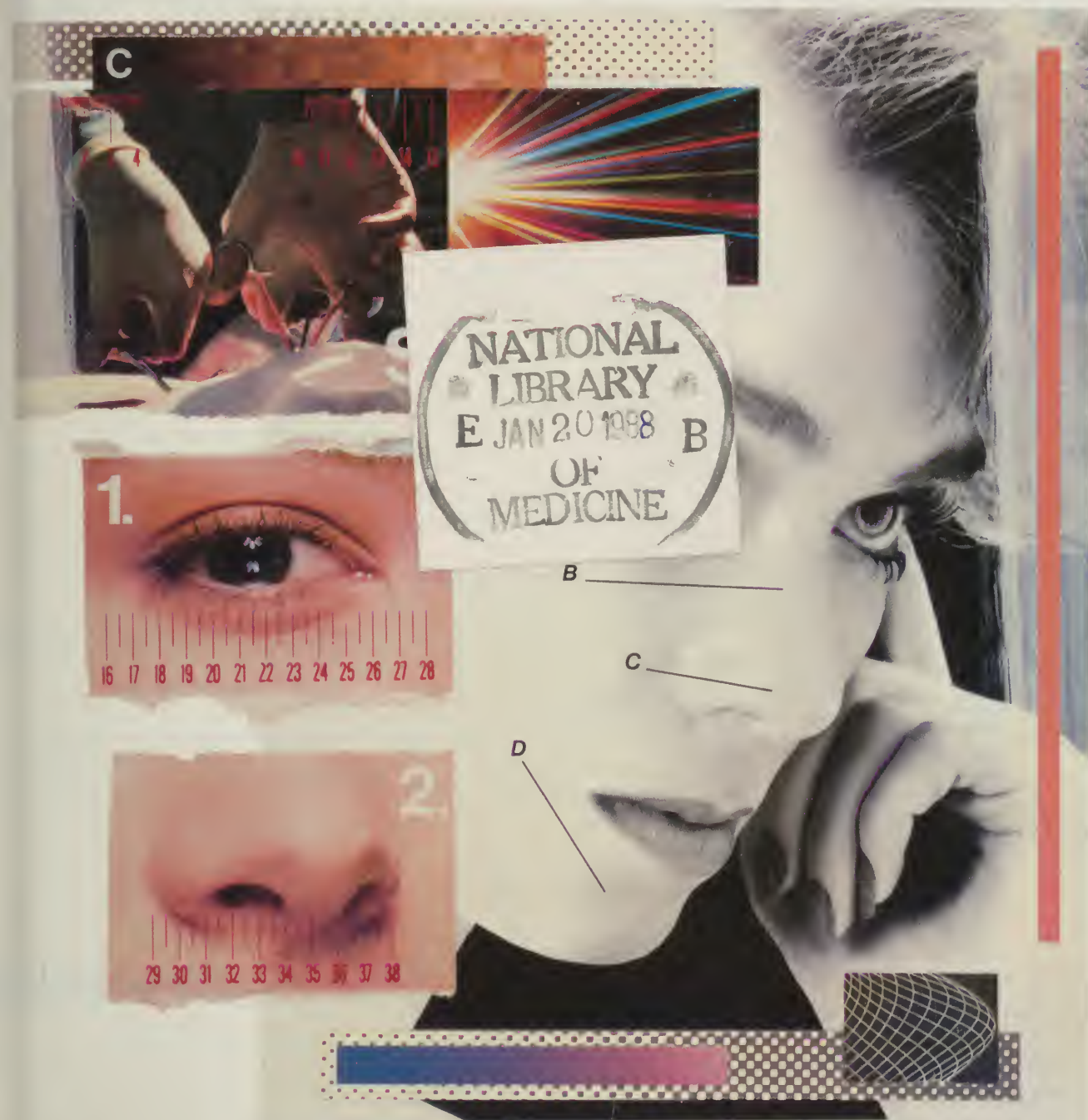
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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

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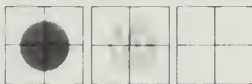
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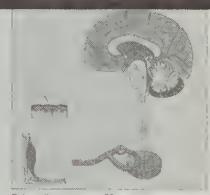
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JANUARY 1988

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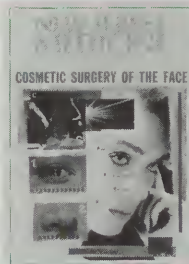
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On The Cover: Our review of some of the newer and more important aspects of facial cosmetic surgery begins on page 22. Cover illustration: Will Harmuth.



As long as medicine faces issues such as soaring malpractice insurance costs, there is a need for doctors to make "house calls" ... a phone call or letter to your government representative. Positive political action is often the only answer to onerous laws that impede the practice of medicine. New Jersey physicians are working to win malpractice insurance reforms under the leadership of the Medical Inter-Insurance Exchange. Sometimes old-fashioned "house calls" are a necessary part of modern medicine.

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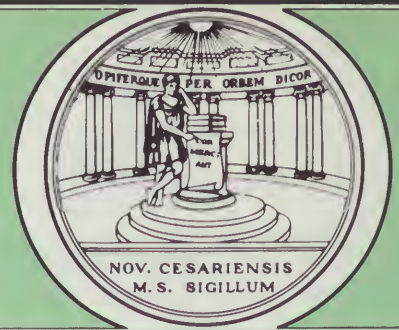
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MEMBERSHIP NEWSLETTER



THE MEDICAL SOCIETY OF NEW JERSEY

VOLUME 5

LEGAL ADVISORY: DO NOT SPEAK TO INVESTIGATORS

It has been reported that investigators from the State Board of Medical Examiners are engaged in blatant misrepresentations to physicians in an effort to obtain information from them. An investigator recently attempted to obtain opinions from three Morris County physicians by lying to them and telling them that she was engaged in a survey. Fortunately, these physicians, all of whom are members of the Medical Society Endorsed Prepaid Legal Services Plan, contacted the program's attorney, Steven Kern, before speaking to the investigator. Mr. Kern was able to assess the problem and discover that the investigator was not involved in a survey, but rather in an investigation.

Had the physicians voluntarily answered the questions of this investigator, they would have found themselves in the middle of an investigation, the scope of which is not known.

This incident once again demonstrates the critical importance of contacting competent counsel prior to making any statements to an investigator or turning over any documents. The Medical Society Endorsed Prepaid Legal Services Plan is designed to provide expert legal counsel to handle just such situations. Members of that plan are urged to consult with a Plan attorney before meeting with any investigators. Those who are not members of the Plan should contact competent legal counsel or take steps to enroll, at their earliest opportunity, in the program. Membership applications for 1988 will be in the mail soon.

MEDICARE REIMBURSEMENT

Physicians can expect automatic cuts of 2.3 percent in their Medicare reimbursement unless Congress and the Administration agree on a budget reconciliation plan to pare the deficit by \$23 billion. If no budget reconciliation bill is signed into law or, if enacted, does not fully meet that budget reduction target, the Gramm-Rudman sequestration process goes into effect. Sequestration would achieve the additional savings needed to meet the \$23 billion target. Roughly equal automatic cuts in domestic and defense spending would be made if sequestration becomes necessary. Approximately \$1.5 billion in budget outlays would be pruned from the Medicare program. Two of the three

Congressional committees involved in health and the legislation reconciliation process—Senate Finance and House Ways and Means—have approved plans to satisfy the \$23 billion target through a combination of \$12 billion in new taxes and reductions in federal spending.

MEDICARE PART B COST CUTS

Faced with unrelenting political pressure to find ways of trimming future increases in Medicare Part B costs, HCFA now is pondering four new or rehearsed options for achieving that objective. The options are: 1) freezing Medicare payments for nonprimary care services; 2) further expanding utilization review activities to deny payments for "excessive, unnecessary and ineligible treatments" (HCFA already is planning to increase these activities by 40 percent to achieve savings of \$520 million); 3) expanding application of the "inherently reasonable" concept; and 4) encouraging patients, through reimbursement incentives and disincentives, to choose physicians HCFA has identified as having "sound practice patterns." Another concept being explored is the possibility of establishing specific Medicare spending targets by region or locality. Fees would be lowered when those targets were exceeded. Asked for his reaction to the various options, James S. Todd, M.D., AMA's Senior Deputy Executive Vice-President, said that HCFA "misunderstands what is driving health care costs today—the increasing number of elderly, the advancing age of the elderly, and the rapid development of new technology." Refinements of these cost-cutting approaches likely will be proposed in President Reagan's fiscal year 1989 budget, the AMA believes.

BREAST CANCER DIAGNOSIS

Despite mammography's usefulness in spotting early breast tumors too small to be felt by physical examination, no more than 25 percent of resulting surgical breast biopsies turn out to show cancerous lesions. But a report in the November *Archives of Surgery* says a new diagnostic technique, in which an x-ray-guided needle samples tumor cells for laboratory analysis, may reduce the need for many of these "open" biopsies. Kambiz Dowlatabadi, M.D., now of Rush Presbyterian-St. Luke's Medical Center, Chicago, and colleagues at the University of Chicago Pritzker School of

Medicine, used this technique, called stereotaxic fine-needle aspiration and cytologic analyses, to examine 84 women with abnormal mammograms. The researchers guided the sampling needle to within 1 to 2 mm of the suspected lesion in 80 cases and resulting cytologic analysis correctly identified 11 of 12 breast cancers (all cases were confirmed by standard biopsy).

"We expect that stereotaxic needle aspiration and cytologic analysis of mammographically detected breast lesions will reduce the need for breast biopsy, thus lowering the threshold of fear in women and indirectly encouraging them to participate more readily in regular screening programs," all the authors conclude.

SPECIAL REPORT: PLANNING YOUR FINANCIAL ROAD MAP

Ask an investor why he or she invests and the answer is likely to be, "To make money." A genuine financial plan, however, should go much further. People have individual financial needs that reflect specific goals and objectives; their financial plans should be tailored to meet those needs.

A useful way to establish investment objectives is to think of money as belonging to three categories: First, there's "absolute" money—what's needed for paying the bills; second, there's "old and grey" money—which is needed for a retirement nest egg; and then there's "discretionary" money—what's left after taking care of the necessities.

Each type of money serves a different purpose. Absolute money should be a certain money as risk free as possible. High yields cannot be expected. This money should also be subjected to the lowest possible volatility. That is, you want to avoid day-to-day price swings.

Short-term money market instruments are the most appropriate for this category. When money is invested for a few weeks or months, interest rate movements won't have a great impact during the holding period. The security will soon mature and return its principal. Treasury bills, backed by the U.S. government, fall into this category, as do many bank accounts, including short-term CDs and money market deposit accounts. They generally are insured by the federal government, up to a maximum of \$100,000. Money market mutual funds don't carry a federal guarantee, but they usually provide a slightly higher yield without any significant risk to principal.

Old and grey money also should be invested conservatively, but some risks might be taken to boost possible returns. The longer an investor has until retirement, the more volatility he or she will be able to tolerate. Over time, an investor is likely to ride out market cycles and earn a better return.

There is some leeway in investing old and grey money. To avoid risks, stay with short-term, fixed-income vehicles—bonds, notes, T-bills, and CDs. By maintaining maturities of six months or less, you'll have virtually as much safety as in your "absolute" money.

Stretching maturities a bit can enhance yield. The extra return may compensate for the risk of losing some principal. Rising interest rates devalue bonds and other fixed-income investments. The longer the bond's maturity, the greater the degree of volatility that is likely to be encountered. At present, it appears that investors who extend maturities to about seven years may receive yields commensurate with the extra risk.

For even higher yields, consider longer term bonds. If interest rates decline, your capital will appreciate. Of course, the converse also is true; if rates rise, you will be left with a capital loss.

Old and grey money may also include equities (stocks or stock funds) for investors willing to live with stock market volatility. Some investors will choose a "growth and income" approach, buying stocks that pay meaningful dividends. Not only is there a current income stream, but those dividends may increase over the years, thereby driving up stock values.

More aggressive investors often prefer to buy stocks strictly for growth. Their goal is capital appreciating rather than dividend income. The rise of the stock market during the past five years illustrates the potential rewards of following this strategy.

As for discretionary money, that's what it is—up to you. You can invest for growth or income. You can be conservative or speculative. Low-priced stocks, high-yield (junk) bonds, currency futures: if you want to take a flier with such investments, they belong in the discretionary sector of your portfolio. Often the most rewarding way for a busy investor to seek aggressive gains in the stock market is through mutual funds that strive for long-term appreciation.

Once the three types of investments are understood, an investor should be able to sit down with a professional money manager or financial adviser and write a road map: Here's where I am now, and here's where I want to go. The road map should have built-in milestones to help chart your path. At least once a year, you and your adviser should review your investment performance and re-examine your objectives.

Modifying your financial road map to account for changes both in your needs and in the economic environment is a natural and ongoing part of the process. It's better to make a series of small adjustments rather than large, abrupt changes. When you make a major shift in strategy, you're likely to be selling the wrong type of asset at the wrong time.

Risk, to an investor, is like stress to a patient. A certain amount is healthy because returns may be increased, but excess risk can be fatal. As we move from stage to stage in the life cycle, our propensity to take risks changes. Sometimes we want more comfort, sometimes less.

For example, a 45-year-old physician may be comfortable being aggressive with his pension fund investments. Short-term reversals won't be disastrous. Over the 20 or 30 years to retirement, he's likely to receive a higher yield in return for taking some risks.

A 65-year-old physician, on the other hand, probably

will be much more cautious with his pension plan. He'll be retiring soon, and he'll want to fix his retirement income with some certainty.

Each individual has unique needs, so he or she should have a unique investment plan. At first, a significant time commitment may be required to ensure that your financial planner fully understands your needs and objectives. Beware of planners who "plug you in" to their pre-set systems. You need a personalized plan, and the greater your involvement in the planning process, the better you'll be able to reach your objectives. Most investors will do best with a mix of money market, fixed-income, and equity investments. That mix should be constantly refined, in keeping with your changing goals.

John E. Turner
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Use in the Elderly: May be increased risk of severe adverse reactions in elderly, particularly with complicating conditions, e.g., impaired kidney and/or liver function, concomitant use of other drugs. Severe skin reactions, generalized bone marrow suppression (see WARNINGS AND ADVERSE REACTIONS) or a specific decrease in platelets (with or without purpura) are most frequently reported severe adverse reactions in elderly. In those concurrently receiving certain diuretics, primarily thiazides, increased incidence of thrombocytopenia with purpura reported. Make appropriate dosage adjustments for patients with impaired kidney function (see DOSAGE AND ADMINISTRATION).

Use in the Treatment of Pneumocystis Carinii Pneumonitis in Patients with Acquired Immunodeficiency Syndrome (AIDS): Because of unique immune dysfunction, AIDS patients may not tolerate or respond to Bactrim in same manner as non-AIDS patients. Incidence of side effects, particularly rash, fever, leukopenia, with Bactrim in AIDS patients treated for *Pneumocystis carinii* pneumonitis reported to be greatly increased compared with incidence normally associated with Bactrim in non-AIDS patients.

Information for Patients: Instruct patients to maintain adequate fluid intake to prevent crystalluria and stone formation.

Laboratory Tests: Perform complete blood counts frequently, if a significant reduction in the count of any formed blood element is noted, discontinue Bactrim. Perform urinalyses with careful microscopic examination and renal function tests during therapy, particularly for patients with impaired renal function.

Drug Interactions: In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombocytopenia with purpura has been reported. Bactrim may prolong the prothrombin time in patients who are receiving the anticoagulant warfarin. Keep this in mind when Bactrim is given to patients already on anticoagulant therapy and reassess coagulation time. Bactrim may inhibit the hepatic metabolism of phenytoin. Given at a common clinical dosage, it increased the phenytoin half-life by 39% and decreased the phenytoin metabolic clearance rate by 27%. When giving these drugs concurrently, be alert for possible excessive phenytoin effect. Sulfonamides can displace methotrexate from plasma protein binding sites, thus increasing free methotrexate concentrations.

Drug/Laboratory Test Interactions: Bactrim, specifically the trimethoprim component, can interfere with a serum methotrexate assay as determined by the competitive binding protein technique (CBPA) when a bacterial dihydrofolate reductase is used as the binding protein. No interference occurs if methotrexate is measured by a radioimmunoassay (RIA). The presence of trimethoprim and sulfamethoxazole may also interfere with the Jaffe alkaline picrate reaction assay for creatinine, resulting in overestimations of about 10% in the range of normal values.

Carcinogenesis, Mutagenesis, Impairment of Fertility: *Carcinogenesis:* Long-term studies in animals to evaluate carcinogenic potential not conducted with Bactrim. *Mutagenesis:* Bacterial mutagenic studies not performed with sulfamethoxazole and trimethoprim in combination. Trimethoprim demonstrated to be nonmutagenic in the Ames assay. No chromosomal damage observed in human leukocytes *in vitro* with sulfamethoxazole and trimethoprim alone or in combination; concentrations used exceeded blood levels of these compounds following therapy with Bactrim. Observations of leukocytes obtained from patients treated with Bactrim revealed no chromosomal abnormalities. *Impairment of Fertility:* No adverse effects on fertility or general reproductive performance observed in rats given oral dosages as high as 70 mg/kg/day trimethoprim plus 350 mg/kg/day sulfamethoxazole.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Trimethoprim and sulfamethoxazole may interfere with folate acid metabolism; use during pregnancy only if potential benefit justifies potential risk to fetus. Nonteratogenic Effects: See CONTRAINDICATIONS section.

Nursing Mothers: See CONTRAINDICATIONS section.

Pediatric Use: Not recommended for infants under two months (see INDICATIONS AND CONTRAINDICATIONS sections).

ADVERSE REACTIONS: Most common are gastrointestinal disturbances (nausea, vomiting, anorexia) and allergic skin reactions (such as rash and urticaria). **FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS (SEE WARNINGS SECTION).**

Hematology: Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, neutropenia, hemolytic anemia, megaloblastic anemia, hypoprothrombinemia, methemoglobinemia, eosinophilia. *Allergic Reactions:* Stevens-Johnson syndrome, toxic epidermal necrolysis, anaphylaxis, allergic myocarditis, erythema multiforme, exfoliative dermatitis, angioedema, drug fever, chills, Henoch-Schoenlein purpura, serum sickness-like syndrome, generalized allergic reactions, generalized skin eruptions, photosensitivity, conjunctival and scleral injection, pruritus, urticaria and rash. *Periarteritis nodosa* and systemic lupus erythematosus have been reported. *Gastrointestinal:* Hepatitis (including cholestatic jaundice and hepatic necrosis), elevation of serum transaminase and bilirubin, pseudomembranous enterocolitis, pancreatitis, stomatitis, glossitis, nausea, emesis, abdominal pain, diarrhea, anorexia. *Genitourinary:* Renal failure, interstitial nephritis, BUN and serum creatinine elevation, toxic nephrosis with oliguria and anuria, crystalluria. *Neurologic:* Aseptic meningitis, convulsions, peripheral neuritis, ataxia, vertigo, tinnitus, headache.

Psychiatric: Hallucinations, depression, apathy, nervousness. *Endocrine:* Sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents; cross-sensitivity may exist. Diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. *Musculoskeletal:* Arthralgia, myalgia. *Miscellaneous:* Weakness, fatigue, insomnia.

DOSAGE AND ADMINISTRATION: Not recommended for use in infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN: *Usual adult dosage* for urinary tract infections is one DS tablet, two tablets or four teaspoonfuls (20 ml) b.i.d. for 10 to 14 days. Use identical daily dosage for 5 days for shigellosis. *Recommended dosage for children* with urinary tract infections or acute otitis media is 8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses every 12 hours for 10 days. Use identical daily dosage for 5 days for shigellosis. *Renal Impaired:* Creatinine clearance above 30 ml/min, give usual dosage; 15-30 ml/min, give one-half the usual regimen; below 15 ml/min, use not recommended.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS: Usual adult dosage is one DS tablet, two tablets or four teasp.

PNEUMOCYSTIS CARINII PNEUMONITIS: Recommended dosage is 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

HOW SUPPLIED: *DS (double strength) Tablets* (160 mg trimethoprim and 800 mg sulfamethoxazole)—bottles of 100, 250 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 20. *Tablets* (80 mg trimethoprim and 400 mg sulfamethoxazole)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension* (40 mg trimethoprim and 200 mg sulfamethoxazole per teasp.)—bottles of 100 ml and 16 oz (1 pint). *Suspension* (40 mg trimethoprim and 200 mg sulfamethoxazole per teasp.)—bottles of 16 oz (1 pint).

STORE TABLETS AT 15°-30°C (59°-86°F) IN A DRY PLACE PROTECTED FROM LIGHT. STORE SUSPENSIONS AT 15°-30°C (59°-86°F) PROTECTED FROM LIGHT.

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Liability Risks and Costs

Liability Pressures in the Medical Group Setting; Doctor-Company Rate Hikes

MEDICAL GROUP LIABILITY PRESSURES

Do physicians in a group practice face a greater or lesser liability risk than solo practitioners? Some argue that there is safety in numbers and that in a multispecialty group practice referrals and communications among physicians are facilitated. In a single specialty group practice the ready availability of physicians to cover for each other is considered an advantage. A group practice may offer a broader range of expertise and ensure that the patient is followed by a physician who has access to the medical record when the primary physician is unavailable.

On the other hand, some observers believe that a group practice is a larger malpractice target with a deeper pocket. Many solo practitioners, mindful that they are completely responsible for the patient, contend that they are more cautious and protective of the patient than are physicians in a group practice in which the continuity of care is disrupted because the patient sees several physicians for one problem. The soloist maintains he has more freedom in selecting consultants and on-call physicians than the group practitioner, because he is not limited to the group.

Insurance company data comparing the claims frequency of group practices and solo practitioners do not conclusively indicate the relative exposure to or insulation from liability of each type of practice. In fact, experts believe it is not exposure, but rather how sound are its overall policies and procedures, including those pertaining to documentation and communication. The largest group practice can be just as safe as an attentive solo practitioner, and vice versa.

Consider these recommendations for reducing or eliminating some of the liability hazards associated with a group practice:

1. **Problem Lists.** Post a problem list on the inside

cover of each patient chart to indicate major medical problems and past surgical procedures. The list assists each physician in a group practice by providing an overview of all care, facilitates history taking, and alerts each practitioner that the medical chart contains examination details and progress notes from the patient's other physicians. A frequent deficiency associated with problem lists is their lack of completeness. Each entry must include the date of onset and, when appropriate, the date of resolution of listed problems. Simply noting a problem without indicating when it was resolved requires the current physician to search the chart for the information to ensure that the problem no longer is an issue.

2. **Separate Progress Note Sections.** In multispecialty groups, use a separate section for each medical service's progress notes to facilitate review of the records. If separate specialty sections are not practical, each progress note should clearly indicate the name of the treating physician and his or her specialty.

3. **Medications.** A substantial number of patient injuries and malpractice claims are associated with poor monitoring of medications and refills. Unless the patient's allergy history, current medication use, and refill record are available, oversights and errors may occur. Consider these safeguards:

- A. Affix a Medication Control Record (MCR) to the inside chart cover on which all medications prescribed are listed. The date, name of the drug, dose, number dispensed, instructions, and identity of the prescriber constitute one complete entry. Refills should be charted in a similar way and include the initials of the aide who phoned the pharmacy. Clearly indicate drug allergies at the top or on a colored label.

- B. Establish and follow a policy requiring each physician in the group to have the chart at hand to review the MCR before prescribing or authorizing refills for his or a colleague's patient. Set guidelines indicating when a colleague's patient must be seen before medication is prescribed or refilled.

- C. Establish and follow a policy which limits the amount of medication physicians in the group can refill for another's patient. Require each physician who prescribes or refills to annotate the MCR. No physician should prescribe or refill a medication with which he or she is unfamiliar or does not regularly prescribe.

- D. Do not permit unlicensed personnel, such as aides, secretaries, nurses, or technicians to prescribe or refill medications without a physician's specific approval. Although some may regard this policy as an inconvenience, it is a small one compared to the trauma of being sued and the risk of injuring a patient because due care was not taken. Aides, clerks, and other unlicensed staff cannot prescribe drugs.

- E. Consider a policy of not authorizing refills, except in very limited quantities, when the chart is not available. Inform patients of this policy in advance and explain how the policy protects them.

4. **Phone Calls.** All phone calls to or from patients in which important information is received or dispensed should be documented in the medical record.

*This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are the Director of the Department and Director of Special Projects, respectively.

**MLM 1987 National Rate Survey
of Physician-Owned Companies
Malpractice Insurance Premium Changes
Last 18 Months—\$1M/\$3M**

State	Percent Change	State	Percent Change
Alabama	+43	Mississippi	+19
Alaska	+25	Missouri	+32
Arizona	+36	Montana*	+35
California	+ 7	Nevada*	+30
Colorado	+73	New Jersey	+ 9
Connecticut	+29	New Mexico	+55
Florida	+36	New York	+ 9
Georgia	+28	North Carolina	+60.4
Iowa	+32.5	Ohio	+31
Kentucky	+46	Pennsylvania	+39.6
Louisiana	+26.1	Tennessee	+12.1
Maine	+25	Utah	+99
Michigan	+20	Wyoming*	+50
Minnesota	+23		

*The Doctor's Company of California
(Percent changes sometimes represent
composites of several companies)

This includes phone reports to patients about laboratory and x-ray test results, appointment reminders, the physician's advice, or other significant information. Use a standard phone message slip, rather than odd slips of paper. Include the patient's complete name, date and time of call, and identity of the person who took the call. File the slips overlap style in the back of the chart in a separate section. In the progress notes, indicate the date and the letters "P.C.," which alerts other physicians that a phone message slip for that date is located in the reserved section. Physicians who take calls outside the office should complete a phone message slip for the chart.

5. **Quality Assurance.** A quality assurance program in a group practice is a safeguard against liability. While there is not space here to describe such programs in detail, two types of reviews are suggested: (1) monthly reviews of a random sample of charts by a quality assurance committee to evaluate appropriateness of care; and (2) concurrent documentation completion audits by trained assistants or nurses using criteria developed by physicians. (*Medical Liability Monitor*, September 23, 1987)

DOCTOR-COMPANIES RAISE RATES

The nation's physician-owned medical malpractice insurance companies posted another round of substantial rate increases in all but a handful of states during the last 18 months.

Medical Liability Monitor's 1987 Annual National Rate Survey of physician-owned companies, covering 32 of 39 insurers, confirmed overall increases ranging from a low of 7 percent in California to 99 percent in Utah. In spite of the huge percentage increase, Utah's current maximum annual premium for high-risk physicians at the \$1 million/\$3 million level is a modest \$41,979, compared to similar coverage for such physi-

**Maximum Medical Malpractice Insurance
Annual Premium for \$1/\$3 Million Coverage**

State	1978	1987
Alabama	\$ 3,444	\$ 37,267
California*	24,000	40,156
Florida	16,800	184,910
Illinois	21,400	63,752**
Mississippi	3,107	30,384
New Jersey	17,412	41,698
New York	22,292	115,240
North Carolina	3,399	28,760
Ohio	5,470	65,831
Tennessee	11,833	23,963

*Medical Insurance Exchange of California.

**Company lists rates quarterly; figure represents current annual rate.

**Maximum Medical Malpractice Insurance Premiums
for Highest Risk Specialties: Selected States
\$1/\$3 Million Coverage**

State	Annual Premium
Oklahoma	\$11,393
Tennessee	23,963
North Carolina	28,760
Mississippi	30,384
Minnesota	30,456
Alabama	37,267
California*	40,156
Connecticut	40,163
New Jersey	41,698
Maine	41,841

*Medical Insurance Exchange of California.

cians in some other states.

The average increase for the reporting companies was 29.9 percent, which ultimately will add more than \$200 million in aggregate written premiums to the annual cost of health care.

The most expensive states for high-risk physicians—such as neurosurgeons and obstetricians—are Florida and New York where maximum annual premiums for \$1 million coverage have soared to well above the \$100,000 level. The most attractive rates are in Oklahoma where the maximum price for \$1 million protection is just \$11,393.

While premiums at the top of the scale can only be termed appalling, it remains that most of the nonsurgical practitioners in the country can still buy \$1 million coverage for \$10,000 or less.

A few states were cautiously optimistic about the future, reporting that the claims frequency appears to be leveling off and the most recent rate increases more modest than in past years. An early 1986 *Medical Liability Monitor* survey of companies indicated an average 38.1 percent projected increase in that year and *Medical Liability Monitor's* 1985 rate survey of 30 companies showed an average increase of 32.3 percent. There was an overwhelming consensus that without a surprise turn-around in the malpractice environment, the increasing severity of an average loss will push rates even higher in the years ahead. (*Medical Liability Monitor*, September 23, 1987, Vol. 12, No. 9)

Before prescribing, see complete prescribing information in SK&F LAB CO. literature or PDR. The following is a brief summary.

Contraindications: There are no known contraindications to the use of 'Tagamet'.

Precautions: While a weak antiandrogenic effect has been demonstrated in animals, 'Tagamet' has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl (brand of cimetidine hydrochloride) injection by intravenous bolus.

Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlorthalidone, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.),

demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported. Including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly un-

likely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only); and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).

Liquid: 300 mg./5 ml., in 8 fl. oz. (237 ml.) amber glass bottles and in single-dose units (300 mg./5 ml.), in packages of 10 (intended for institutional use only).

Injections:

Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose prefilled disposable syringes.

Plastic Containers: 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

ADD-Vantage® Vials: 300 mg./2 ml. in single-dose, ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl (brand of cimetidine hydrochloride) Injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

* ADD-Vantage® is a trademark of Abbott Laboratories.

BRS-TG-1738

Date of issuance Apr. 1987

SK&F LAB CO.

Cidra, P.R. 00639

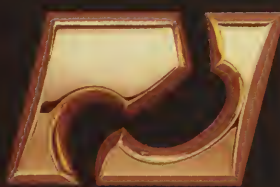
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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

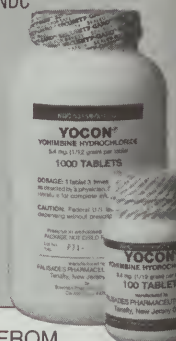
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27-2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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We are proud of NEW JERSEY MEDICINE. And, we have reason to be. The results of the latest readership survey are in and—without a doubt—NEW JERSEY MEDICINE stands out above the crowd. We know you, our readers, have plenty of material to peruse, but it is a great feeling to know that every month you check in with us! NEW JERSEY MEDICINE participated in a readership study conducted by Health Industries Research of Wilton, Connecticut. This study sought two types of information: feedback for the editorial staff, and qualitative and quantitative measurements of interest levels and reading patterns to assist advertisers in their decisions to purchase state journal advertising space.

In conjunction with 11 other state medical societies—from large to small and from urban to rural—we took part in a “focus technique” readership study. This technique, perfected by Health Industries Research, measured how frequently and how thoroughly physicians read medical publications.

All state medical journals—without exception—are very well read. Data showed that nearly all physicians read at least one of every four issues, an indication for an advertiser of “total reach of a publication.” In general, all state journals studied had strong readership profiles (Table 1).

Our random sampling of readers—a healthy 68.8 percent—proved that NEW JERSEY MEDICINE is well read. Ninety-five percent of physicians in New Jersey read at least some issues and over half, 56 percent, read every issue of the state medical journal. Seventy-eight percent of physicians in the Garden State read an average issue (Table 2).

The editorial staff looked to this study to see what you, our readers, want. Firstly, 88 percent of our readership said they definitely want to continue receiving their copy of NEW JERSEY MEDICINE. Health Industries Research states that this statistic indicates a high level of satisfaction with our state medical journal. Most of the features of NEW JERSEY MEDICINE appeal to over 90 percent of our readers. Respondents were asked to express their interest level for some specific features in each issue:

Feature	Readership
Scientific Articles	94%
Professional Liability	
Commentary	94%
Membership Newsletter	87%
CME Calendar	64%
Book Reviews	55%

The completed study showed a good balance of interest in our selection of featured articles. With competition from major national medical and specialty

TABLE 1

State	Average Issue Readers	Issue Ad Exposure	Continue to Receive	Reading Time in Min.
Georgia	83%	49%	93%	36
Kentucky	80%	41%	95%	31
Kansas	77%	39%	89%	27
Louisiana	75%	39%	88%	27
Maryland	76%	40%	94%	31
Michigan	76%	40%	89%	27
New Jersey	78%	41%	88%	33
Pennsylvania	76%	39%	91%	28
South Dakota	82%	53%	96%	30
Texas	69%	31%	87%	32
West Virginia	88%	52%	94%	35
Total	78%	42%	91%	31

TABLE 2

Reading Frequency	4 of 4	3 of 4	2 of 4	1 of 4	0 of 4
Total	58%	16%	13%	8%	5%
Journal of the Medical Association of Georgia	61%	20%	12%	4%	3%
Journal of Kentucky Medical Association	62%	15%	9%	10%	4%
Kansas Medicine	55%	15%	15%	10%	4%
Journal of Louisiana State Medical Society	53%	15%	14%	13%	5%
Maryland Medical Journal	54%	18%	4%	6%	9%
Michigan Medicine	50%	23%	13%	9%	5%
NEW JERSEY MEDICINE	56%	16%	15%	8%	5%
Pennsylvania Medicine	57%	12%	16%	7%	7%
South Dakota Journal of Medicine	66%	14%	8%	6%	6%
Texas Medicine	48%	11%	19%	10%	11%
West Virginia Medical Journal	72%	14%	9%	3%	2%

Reading Patterns	Cover to Cover	Read/Look	Pages	Table of Contents to Pages	Average Issue Readers	Average Issue Ad Exposures
Total	3%	57%	15%	25%	78%	42%
Journal of the Medical Association of Georgia	3%	66%	8%	23%	83%	49%
Journal of Kentucky Medical Association	3%	51%	14%	33%	80%	41%
Kansas Medicine	2%	53%	17%	28%	77%	39%
Journal of Louisiana State Medical Society	1%	57%	17%	25%	75%	39%
Maryland Medical Journal	4%	51%	21%	24%	76%	40%
Michigan Medicine	1%	54%	20%	24%	76%	40%
NEW JERSEY MEDICINE	4%	55%	11%	30%	78%	41%
Pennsylvania Medicine	—	54%	21%	25%	76%	39%
South Dakota Journal of Medicine	6%	72%	9%	13%	82%	53%
Texas Medicine	1%	45%	11%	43%	69%	31%
West Virginia Medical Journal	8%	59%	17%	16%	88%	52%

journals, our state medical publication "holds its own" in the eyes of New Jersey physicians. Additional written comments proved the statistics correct with statements like, "Keep up the good work" and "A good journal."

And, be assured, we are not going to rest on our

laurels. We plan to refer back to the survey and make our state journal a more effective instrument of communication. However, the individual opinions of our readers still remain paramount if *NEW JERSEY MEDICINE* is to be responsive to your needs. Write to us at any time and let us know your feelings. G.F.

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Cimetidine:

All patients	76.3%
Smokers	62.5%

*Significantly greater than cimetidine smoker group ($P < .05$).

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BRIEF SUMMARY

CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate.

PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that the simultaneous administration of CARAFATE with tetracycline, phenytoin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. The clinical significance of these animal studies is yet to be defined.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No evidence of drug-related tumorigenicity was found in chronic oral toxicity studies of 24 months' duration conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies have not been conducted.

Pregnancy: Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients, adverse effects were reported in 121 (4.7%). Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED

CARAFATE (sucralfate) 1-gm pink tablets are supplied in bottles of 100 and in Unit Dose Identification Paks of 100. The tablets are embossed with MARION/1712.

Issued 3/84

References:

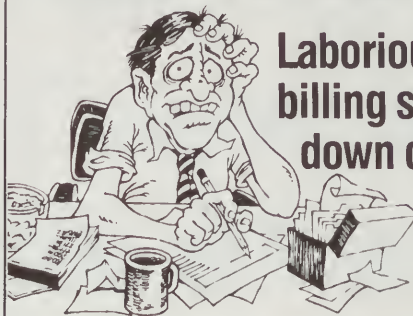
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DRGs and New Jersey

The New Jersey Diagnosis Related Group program has been a matter of controversy from its inception.

The New Jersey Diagnosis Related Group (DRG) program has been, and continues to be, opposed to the DRG method of reimbursement because the Society views the program as fatally flawed. While the computer may "fit" the universe of patients into any one of the 467 DRG classifications, clinical realities make the concept unworkable.

It is difficult to measure the impact of such a program on patient care; however, it is commonly accepted that patients are being discharged "quicker and sicker." No matter which way the debate moves, it is readily acknowledged that patients are being discharged into an environment that clearly cannot meet their needs as ill or injured people needing time to heal.

The economic architects that devised and manage the system have not tolerated criticism very well. Their standard and only response is that such criticism is "anecdotal" and therefore nonmeritorious. As an attorney, I find that to be a rather amusing posture. In a court of law, the most valid evidence is considered to be direct testimony from a creditable eyewitness. I guess we will never overcome the carrier of perspective distortion. At a given point, however, it must be accepted that events do occur without being witnessed at the time or occurrence: leaves drop whether we see them or not.

The article by Professor Sapolsky (page 32) is the first indepth analysis of the New Jersey DRG program by an impartial and out-of-state researcher. He is one of the very few people that does not make the mistake of confusing our reimbursement statute (Chapter 83 of the Laws of 1987) with the requirement of a DRG methodology. The Medical Society of New Jersey has submitted three formal requests to the State Department of Health asking that an authoritative, out-of-state entity be commissioned to conduct an evaluation of the impact of the program on the quality of patient care. The Department has issued three declinations. Hopefully, Dr. Sapolsky's paper will stimulate debate and lead to further evaluation. This article is "must" reading for anyone concerned with hospital care in New Jersey.

Vincent A. Maressa
Executive Director
Medical Society of New Jersey

EDITOR. The Medical Society of New Jersey is accepting applications for the position of Editor of *NEW JERSEY MEDICINE*, the state medical journal. The Society's Executive Committee is seeking an experienced medical editor who can combine a strong scientific background with a keen interest and awareness of Medical Society affairs; an M.D. is required. The Editor is responsible for the editorial content of the monthly journal; the position is part-time. Please send a letter outlining your qualifications and a copy of your c.v. to the Executive Committee, MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

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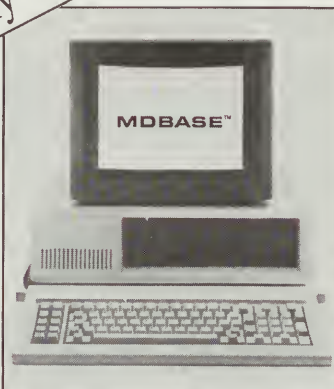
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Contraindications: Known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) reported after abrupt cessation of extended use of excessive doses are similar to those seen with barbiturates. Milder symptoms reported infrequently when continuous therapy is abruptly ended. Avoid abrupt discontinuation; gradually taper dosage.

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Due to isolated reports of exacerbation, use with caution in patients with porphyria.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extropyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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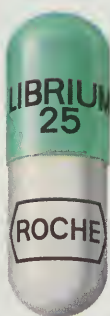
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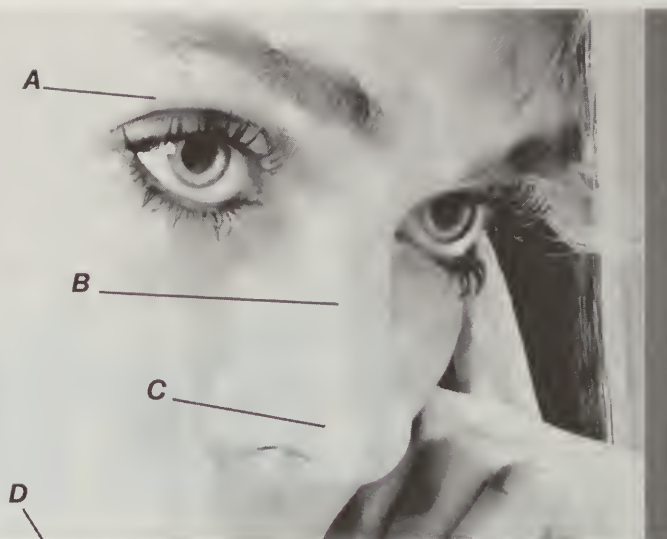
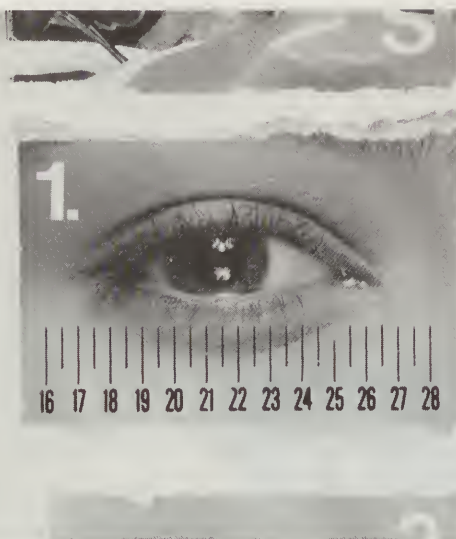
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COSMETIC SURGERY OF THE FACE

ALVIN I. GLASGOLD, M.D., HIGHLAND PARK*

The increasing interest in facial cosmetic surgery is a trend that will continue. Keeping abreast of advances in this field can be difficult. This review will describe some of the newer and more important aspects of facial cosmetic surgery.

RHINOPLASTY

The "open approach" to rhinoplasty has added an exciting new dimension to an old operation. The exposure, utilizing a transcolumella incision followed by elevation of the nasal skin, allows for greater accuracy in correcting certain nasal deformities. The external scar is not a problem and this procedure has been a great help in dealing with difficult problems, specifically for the correction of the traumatized, twisted nose and the poorly defined broad tip, and for revision nasal surgery.

The advantage of the open approach is the greater exposure, visualization, and more accurate diagnosis. The structural defect can be corrected by trimming, repositioning, and cartilage grafting. The broad, flat tip now can be projected by using large cartilage struts sutured in position (Figures 1A and 1B).

Revision rhinoplasty always has been a dilemma for the nasal surgeon. A major disadvantage is undertaking a procedure in an already unhappy patient. As a result of scarring and other factors, achieving predictable improvement in revision surgery is difficult. Many capable surgeons have been reluctant to perform revision surgery which leaves an unhappy patient with no options. The open approach has allowed for more accurate correction of problems with a more predictable result.

*Dr. Glasgold is Associate Professor of Surgery, UMDNJ-Robert Wood Johnson Medical School, Piscataway. Correspondence may be addressed to Dr. Glasgold, 31 River Road, Highland Park, NJ 08904.

FACIAL CONTOUR SURGERY

In the past, rhinoplasty has been our major tool in changing facial outlines, but we now do facial contour surgery. Mentoplasty often was done as an associate procedure for micrognathia. We now work with our dental colleagues to realign the lower third of the face through orthodontics and mandibular repositioning. Newer techniques for midface surgery allow significant improvements in severe midface deformities. For the most part, however, we are dealing with less severe facial defects in cosmetic surgery. Malar, as well as mental, augmentation is being combined with other cosmetic procedures. Implantable prostheses placed through intraoral incisions or small external incisions improve facial appearance. The surgery is relatively simple, adds little operating time, and the prostheses are well tolerated. Complications such as infection and rejection are rare, as are shifting or asymmetric placement. Repositioning or removal and reinsertion of new implant may be accomplished without difficulty. Patient satisfaction has been great. Many patients request rhinoplasty, which alone would produce only slight improvement. Small recontouring procedures plus rhinoplasty often can change ordinary results into excellent results (Figures 2A and 2B).

Suction lipectomy, the newest addition to facial contouring, was first popularized in the United States by Newman and others.¹ The technique and instrumentation has been improved greatly during the past five years. In the face, it is used predominantly in the nasolabial folds, the jowls, and the submental region. Liposuction contouring of the nasolabial groove through intranasal incisions has limited value, but may be augmented by injecting filling material. Liposuction for the jowls and submental region through a small submental incision has been of f



Figure 1A—Traumatic nasal deformity. Note the asymmetry as well as the broad flat tip.



Figure 1B—Postoperative correction by open rhinoplasty.



Figure 2A—Preoperative view of patient who underwent revision rhinoplasty through open approach.



Figure 2B—Postoperative view of completed tip projection, with malar and mental augmentation and upper and lower lid blepharoplasty.



Figures 3A and 3B—Pre- and postoperative view of patient treated with facial liposuction in conjunction with facelift and augmentation of the malar and mental regions.

greater value, especially in the younger patient with good skin elasticity. As skin elasticity is lost, liposuction combined with facelift and/or mentoplasty compensates for skin laxity (Figures 3A and 3B). Facial liposuction alone or in combination with mentoplasty is a quick, very safe office procedure. The blunt cannula of the liposuction device is not likely to injure vessels or nerves. Liposuction with facelift has improved significantly the contouring effect in the jowl and submental regions and shortens operating time.

Facial contouring with injectable materials such as collagen Zyderm® and Zyplast® may produce excellent short-term results. Long-term results with injectable silicone have been more reliable, but the earlier use of injectable silicone produced significant problems. The material fell into disfavor and has not been approved by the FDA. Orentreich and others have shown silicone to be safe and effective when used appropriately, i.e. in very small quantities over a long period of time.^{2,3} Webster has written on the silicone microdroplet technique.^{4,5} Those familiar with silicone feel it is safe and provides excellent long-term results; they hope silicone

will gain FDA approval in the future.

Fat recycling involves the harvesting of fat by liposuction and reinjecting it to fill facial defects. Autogenous fat is a natural contour material and is easily obtained through small punctures under local anesthesia, but long-term fat survival with the present methods of recycling is questionable. Studies now are in progress on the basic nature of fat harvested from different areas of the body as well as the operative instrumentation.

Improved surgical techniques have reduced operating time, allowing performance of multiple procedures at one time, while advances in anesthesiology allow greater margin of safety with both general anesthesia and local anesthesia combined with intravenous sedation.

CONCLUSION

The challenge to improve facial appearance continues to advance our surgical skills. As a result, we are able to offer patients better results with less morbidity.

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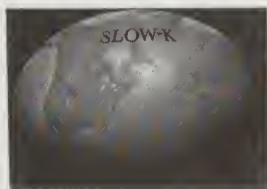
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References: 1. Data on file, CIBA Pharmaceutical Company. 2. Skoutakis VA, Achiaro SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. 3. Skoutakis VA, Carter CA, Achiaro SR: Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

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1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.
2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure; hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.
3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, renal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS

Hyperkalemia (See OVERDOSAGE).

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS

General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients

Physicians should consider reminding the patient of the following:
To take each dose without crushing, chewing, or sucking the tablets.
To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.
To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests

Repeat serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions

Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproductive capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions are present in many of these patients.

The most common adverse reactions to oral potassium salts are vomiting, abdominal discomfort, and diarrhea. These symptoms are irritation of the gastrointestinal tract and are best managed by taking doses with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, excretory mechanisms are impaired or if potassium is administered rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of S-T segment, and prolongation of the Q-T interval). Manifestations include muscle paralysis and cardiovascular collapse, cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) restriction of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 mEq/hr dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) treatment of acidosis, if present, with intravenous sodium bicarbonate; (4) exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on a low potassium diet, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

OSAGE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq/day. Potassium depletion sufficient to cause hypokalemia usually results in the loss of 200 or more mEq of potassium from the total body store. The dose must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

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THE USE OF THE CARBON DIOXIDE LASER DURING LAPAROSCOPIC SURGERY

HERBERT A. GOLDFARB, (M.D., MONTCLAIR*)

Laparoscopy is a most useful means of evaluating the causes of pelvic pain and infertility. Since the introduction of the carbon dioxide laser laparoscope, these conditions can be treated laparoscopically. This procedure is suitable for all hospitals and surgical centers if used by trained surgeons.

The laparoscope is an invaluable tool, providing the gynecologist with a means of visualizing and diagnosing certain pelvic diseases or abnormalities without resorting to laparotomy. Adapted with cutting or electrocoagulating forceps, the laparoscope also can be used to carry out a variety of intra-abdominal surgical procedures. The most significant and promising adaptation of the laparoscope in recent years has been gynecologic laser surgery.

The laser laparoscope is designed to allow the passage of a single beam of light emitted from a carbon dioxide (CO₂) laser through a coupler attached to the operating channel of a specially designed laparoscope or to a second puncture probe. The beam of monochromatic light can be focused through the instrument's lens system and fired at the desired tissue with pinpoint precision.¹⁻³ The laser may reduce bleeding, operating time, tissue handling, postoperative adhesion formation, and patient recovery time.⁴

Since the laparoscope is employed routinely to diagnose infertility and pelvic pain, the availability of laser for use in conjunction with laparoscopy may afford the physician and patient an immediate, complete, and low-risk alternative to laparotomy or lengthy courses of drug therapy.

We conducted a retrospective review of the clinical records of 199 patients to assess the value of laser

equipment during routine laparoscopic procedures.

MATERIALS AND METHODS

The clinical records of 199 women admitted to the hospital between January 1, 1985, to May 31, 1987, for possible laser laparoscopy were reviewed retrospectively. The study included patients who were undergoing evaluation for infertility. The remaining patients underwent laparoscopy for the diagnosis and possible treatment of symptomatic pain or positive physical findings noted on physical examination, such as palpable masses or nodules. Prior to laparoscopy, each of these patients underwent a complete infertility study, which included semen analysis, postcoital testing, endometrial biopsy, basal body temperature recordings, and hormonal evaluation.

Written informed consent for laparoscopy and possible laser treatment was obtained from all patients. The procedure was performed under general endotracheal anesthesia with the 40-watt Sharplan 730 CO₂ laser,[†] the Wolf laser laparoscope,[°] the Wolf cin arc

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†Advance Surgical Technologies, Allendale, NJ.

°Richard Wolf Medical Instruments Corp., Rosemont, IL.

light source, and Stryker camera (tube type). The average power to lyse endometriotic implants ranged from 5 to 20 watts. Second and third suprapubic punctures were made as needed to properly isolate tissues for laser safety. A second puncture Wolf 300 mm laser delivery system with backstop and 200 mm laser spectrum delivery system were used when extensive adhesiolysis was performed. At the completion of the procedure, 60 cc of 32 percent dextran 70 was instilled in the abdominal cavity and the incision sutured. The average length of surgery ranged between 1.5 and 2 hours. A surgical assistant is available if laser therapy is required. Patients underwent laparoscopy the day of admission and remained in the hospital for overnight observation to rule out any postoperative complications.

RESULTS

Of the 199 women who underwent laparoscopy, 104 women (52 percent) were treated surgically with the CO₂ laser. Forty-seven of these patients underwent treatment at the time of laparoscopic diagnosis for infertility. The major finding among these patients was endometriosis. One of the patients treated had pelvic adhesions completely enveloping both ovaries; laser surgery freed one ovary and the homolateral tube and a successful pregnancy was achieved shortly thereafter. To date, 16 of the 47 (34 percent) infertility patients treated with the laser laparoscope have become pregnant. Most infertility patients had previous operative procedures. The most common finding among the noninfertility patients who underwent laser laparoscopy for pelvic pain also was endometriosis.

COMPLICATIONS

Over the course of two years and 104 laser laparoscopies, bleeding from the uterosacral ligament occurred in one patient and was the only major complication encountered. The bleeding affected vascular stability 12 hours after surgery, and required laparotomy and suturing of the uterosacral artery. The diagnosis was stage III endometriosis; pregnancy was achieved subsequently. Other complications included three cases of urinary retention secondary to lysis of en-

dometrial implants on the anterior bladder wall.

DISCUSSION

Laparoscopy currently is the second most frequently performed gynecological procedure, second only to curettage. It usually is performed for primary sterilization. A high percentage of women with pelvic pain but no obvious pathology, have significant findings at the time of laparotomy. In this study, 104 of the 199 women evaluated at the time of laparoscopy were judged to have pathology suitable for laser laparoscopic treatment.

The procedure for the laser laparoscopic surgery requires a second, and occasionally a third, puncture site. A Daniell laser spectrum second puncture delivery system was used during the early period of this study. A Wolf laser focusing cube was used during the latter phase of this study. The operating single puncture laser was considered sufficient for most procedures and could be manipulated with greater ease than the one described by Daniell.² The only limiting factor, of course, is the skill of the operator.

All procedures are viewed and recorded using a video camera which aids the laparoscopist in manipulating and fixing the tissues during surgery, and allows the patient to understand the course of treatment taken.

The laser laparoscope is fully approved by the FDA and represents a significant advance in the field of reproductive medicine. The laser laparoscope is a good choice for hospitals and surgical centers.

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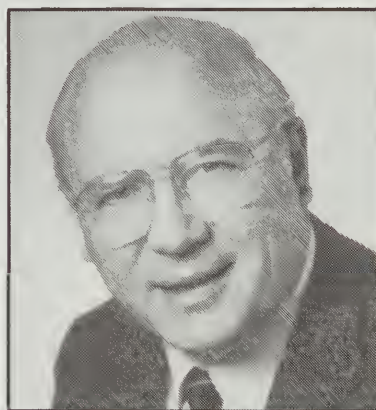
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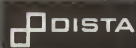
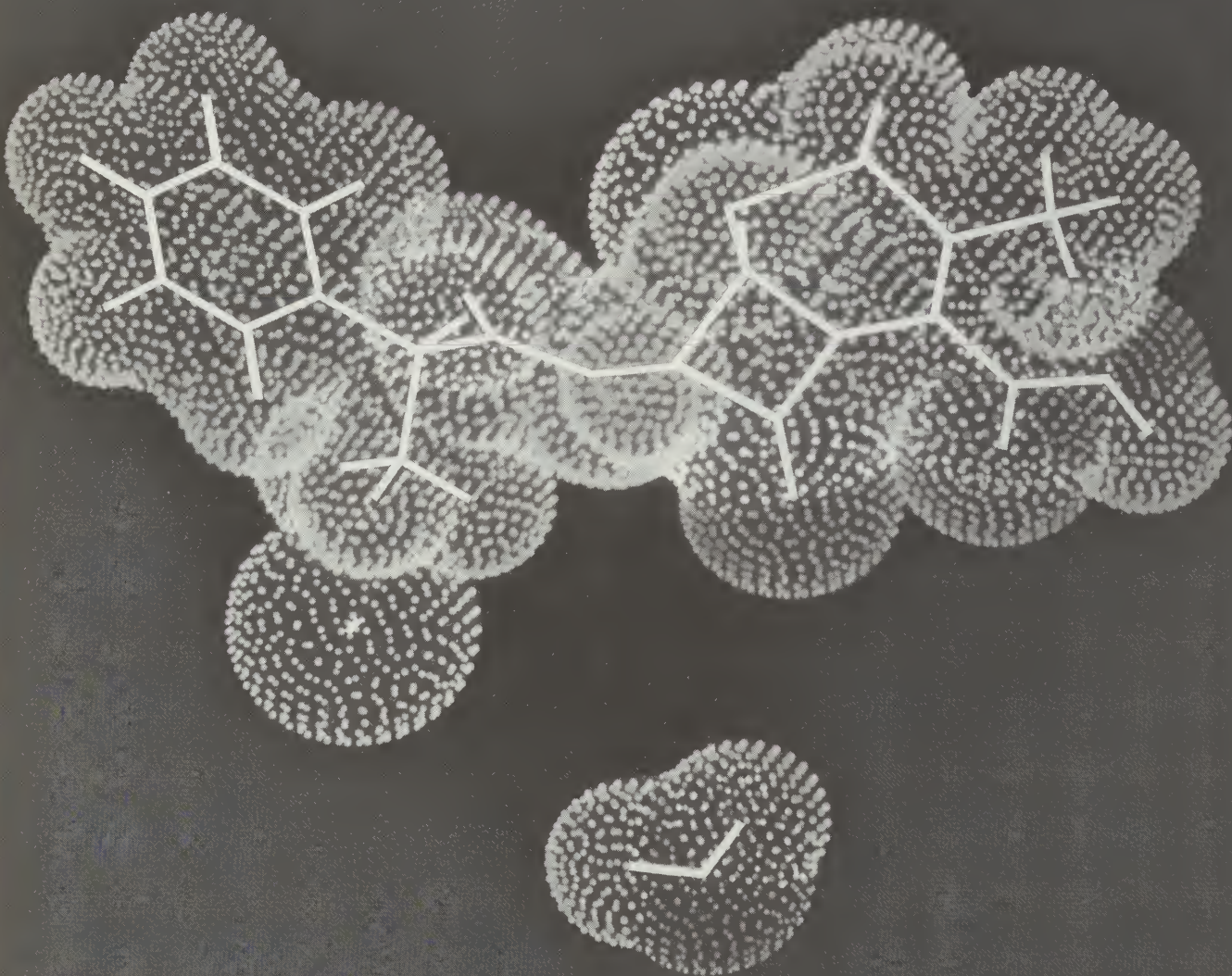
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Bone infections caused by susceptible strains of *S aureus* and/or *Proteus mirabilis*.

Genitourinary tract infections, including acute prostatitis, caused by susceptible strains of *Escherichia coli*, *P mirabilis*, and *Klebsiella* sp.

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Warnings: KEFTAB SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Keftab in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Keftab should be administered cautiously in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy and lactation. Cephalexin is excreted in mother's milk. Exercise caution in prescribing Keftab for these patients.
- Safety and effectiveness in children have not been established.

Adverse Reactions:

- *Gastrointestinal*, including diarrhea and, rarely, nausea and vomiting. Transient hepatitis and cholestatic jaundice have been reported rarely.
- *Hypersensitivity* in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson syndrome, or toxic epidermal necrolysis.
- *Anaphylaxis* has been reported.
- *Other reactions* have included genital/anal pruritus, genital moniliasis, vaginitis/vaginal discharge, dizziness, fatigue, headache, eosinophilia, neutropenia, and thrombocytopenia; reversible interstitial nephritis has been reported rarely.
- Cephalosporins have been implicated in triggering seizures, particularly in patients with renal impairment.
- *Abnormalities in laboratory test results* included slight elevations in aspartate aminotransferase (AST, SGOT) and alanine aminotransferase (ALT, SGPT). False-positive reactions for glucose in the urine may occur with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

AN EVALUATION OF THE NEW JERSEY DRG HOSPITAL PAYMENT SYSTEM

HARVEY M. SAPOLSKY, (PH.D., CAMBRIDGE, MASSACHUSETTS*)

The benefits and limitations of the New Jersey all-payer hospital reimbursement system are described, with emphasis on Diagnosis Related Groups (DRGs). Implementation problems and other areas of concern are noted as are multiple and conflicting goals of health policy that constrain governmental action.

In 1980, New Jersey introduced a new system for reimbursing hospitals utilizing the Diagnosis Related Group (DRG) method for determining rates. The state was the first in the nation to adopt this approach for hospital payment. In 1983, the federal government required the use of a modified version of DRGs for its Medicare program. Subsequently, the Robert Wood Johnson Foundation commissioned an evaluation of the New Jersey experience with the DRG payment system.¹ Here, I summarize the main findings and conclusions of the evaluation.

An important distinction needs to be made between hospital reimbursement reform in New Jersey and the selection of DRGs as the payment methodology. Senate Bill 446, the reform legislation enacted in 1978, was intended primarily to address two problems.¹ One problem was growth of bad debt that was threatening the financial viability of inner-city hospitals which served a large portion of the Medicaid and uninsured populations in the state. The other problem was the increasing differential that was developing between regulated Blue Cross rates and the uncontrolled charges that private insurers and individuals had to pay. The solution was to discard the then existing rate regulation scheme known as SHARE which regulated only Blue Cross and Medicaid rates for an all-payer arrangement which actually would share reimburse-

ment burdens equitably among all who paid for hospital services.² Under the all-payer arrangement implemented, Medicare and Blue Cross absorbed a portion of the bad debts hospitals incurred and the rate differential between Blue Cross and private insurers was much reduced.

The New Jersey approach to hospital payment stands in contrast to current national policy, which is best described as a "beggar thy neighbor" strategy. The federal government, wishing to hold down its own costs, limits Medicare payments to predetermined rates. Hospitals, not fully reimbursed for care provided, seek to avoid losses by shifting costs to private payers. Powerful private purchasers attempt to protect themselves from this cost shifting by demanding discount

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¹The project team was composed of Sanford Weiner, James Maxwell, and Dr. Sapolsky from MIT and William Hsiao and Daniel Dunn from the Harvard School of Public Health. Collaborators included James Aisenberg of the Harvard Medical School, Stan Finkelstein of MIT, James Morone of Brown University, and Richard Greene of the Veterans Administration. None of these individuals or organizations or the Robert Wood Johnson Foundation are responsible for any finding or conclusion reported here. The author thanks the Foundation for its support.

In turn, this places further burdens on those payers who lack market power and those hospitals that lack a large clientele of well-insured patients. As a result, problems that were addressed in the 1978 New Jersey reform of hospital reimbursement are growing in importance nationally. Hospitals that treat a disproportionate share of uninsured or underinsured patients are experiencing increased operating losses and the differential in rates paid by insurers is increasing due to discounting.³

The New Jersey approach has much to commend it. The all-payer arrangement guarantees both the financial solvency of New Jersey hospitals and the access to hospital care for all residents of the state without forcing particular classes of insurers to absorb alone the costs of these regulatory requirements. Instead, the costs of protecting hospitals and individuals are distributed via a negotiated formula among all those who finance hospital care within the state. The federal officials, concerned with the budget deficit, have chosen a different path, one which emphasizes limits on federal expenditures rather than provider solvency or increased patient access. Because of this, the renewal of the special waiver of standard federal procedures that permits Medicare to participate in the New Jersey all-payer arrangement stands in jeopardy.⁴

DRG: SELECTION AND IMPACT

Senate Bill 446 mandated that reimbursement be made utilizing a system that recognized case-mix variations among hospitals, but did not specify the methodology to be used by the State Department of Health in implementing the law.⁵ The Department selected the DRG system, a case-mix methodology developed at Yale University, primarily due to its promise to encourage improvements in hospital efficiency which would lead to lower costs and better care. Under the DRG system, hospitals are paid predetermined rates for care provided patients classified by diagnosis. Because hospitals are allowed to retain the difference between the predetermined rates and their actual costs in providing care, they have incentive to improve efficiency. Conversely, because hospitals must absorb within certain boundaries costs that exceed the predetermined rates, inefficiency is penalized.

The Yale researchers who devised the DRG system had sought initially to improve hospital cost accounting by applying the standard techniques of industrial management, especially product line accounting, to hospital settings.^{6,7} They believed that efficiency gains would result if hospitals could identify the costs required to produce particular hospital products or outputs. Their search for a hospital analogy to a manufacturer's product led them to classify admissions and costs by diagnosis. When hospitals appeared uninterested in the new accounting system—hospitals had no need to be concerned about cost control under the then prevailing retrospective cost reimbursement arrangements—the Yale researchers sought to link DRGs to reimbursement and compel an interest in efficiency.⁸

In the late 1970s when the DRG system was being formulated, the federal government was blocked by Congress from instituting a national scheme to control hospital costs. It then began to encourage the states

to experiment with their own cost control programs. New Jersey was an early volunteer and received federal grants to revise and implement the DRG system.

The team the state assembled to manage the DRG experiment recognized that hospital costs were largely determined by the clinical decisions of physicians.⁹ Hospital administrators would have to influence these resource use decisions if the system's cost control objectives were to be achieved. New Jersey's all-payer arrangement would help by providing hospitals with consistent rates for patients treated for the same diagnosis classification. The actual rates were to be based on the historic cost experience of statewide groupings of hospitals for each diagnosis. Periodic need to adjust the DRG rates to reflect recent experience and new technology would allow for the rates to be pushed down to the point at which physicians would be forced to accept direction about their resource use from administrators if hospitals were to remain solvent. Implementation of the system began in 1980. By 1983, all of the state's hospitals were being reimbursed by DRGs.

Our evaluation examined the overall economic impact of DRG regulation and the effect on hospital management. To determine the effect on hospital costs, we compared hospital experience in New Jersey before and after the introduction of DRGs. Length of hospital stays declined with the use of DRGs, but admissions increased somewhat. Measured on hospital expenditure per capita basis, the rate of hospital cost inflation was fairly constant under both SHARE and DRG regulation. New Jersey's rate of hospital inflation was below regional and national averages with DRGs, but so was it under the SHARE system. Overall, the economic impact of DRGs was quite negligible.¹⁰

To explore the effect on management, we conducted interviews at a stratified sample of hospitals in New Jersey. There was no discernible effect on clinical practices. Some hospitals had to curtail expenditures, but others found their margins improving. Those that had to trim expenditures reduced staffing or sought better supply prices. Several hospitals expanded services, particularly unregulated services, to increase revenues. There was much collection of DRG data, but little attempt to use this information to influence physician behavior. The reduction in length of stay was across the spectrum of care, affecting profitable DRGs as well as unprofitable ones. The clinical authority of physicians remained unimpaired.⁸

No doubt the failure of DRGs to alter the overall cost of care or the management structure of hospitals was due in large part to the fact that DRG rate regulations were no more constraining than were SHARE regulations. When the DRG regulations were being drafted, hospital administrators sought and obtained a number of important concessions. They were worried about the uncertain impact of an untried system on their facilities and preferred to make the system as familiar as possible. The approved rates were based more on individual hospital experience rather than class averages. The outlier trim points (which determine the range of costs that would be considered average) were set narrowly so that much of the care given was to be reimbursed outside the DRG system on the basis of the actual cost incurred. Outpatient care, capital ex-

penditures, and various overhead categories also were reimbursed outside the DRG system.

The state agreed to these and other concessions in order to gain hospital cooperation in the difficult transition to the new rate system. It was thought that the lure of profits permitted in the DRG system might be enough to produce the desired results and, if that was not sufficient, then the system could be tightened in the periodic rebasing of rates. Neither occurred.

Hospitals, it seems, are more complex organizations than the DRG designers envisioned.¹¹⁻¹³ Professional incentives are at least as important in determining hospital behavior as are economic incentives. With the law and the initial rates ensuring financial stability, additional profits had no lure. When hospital margins improved, surpluses were quickly absorbed in buying new equipment or hiring additional staff. Hospitals that were inattentive did risk losses. As was indicated, however, they used traditional revenue enhancing and cost-cutting methods to recover financial health. Hospital administrators had no desire to challenge the authority of physicians. On the contrary, they considered their role as insulating clinicians from the vagaries of rate regulations. Whether through lobbying or the management of hospital resources, the goal of administrators was to protect clinical decisions rather than to influence them. Their success in obtaining this goal was evident in the fact few physicians interviewed knew or cared much about the change in reimbursement methodology.

The question then becomes why was not the system tightened to achieve structural changes and cost reductions. The regulatory concessions were thought to be only temporary, yet they largely remain in place. The ratcheting down of the DRG prices, which on its own could have forced the desired results, did not happen.

THE PROBLEM OF INNOVATION IN GOVERNMENT

The federal grants permitted the Department of Health to hire a special staff to manage the DRG project.⁵ Such a staff was thought necessary because officials viewed the department's regular employees as being too unimaginative to cope with the complex tasks involved in implementing the innovative, but untried reimbursement system. With the attraction of a challenging project and higher than customary state salaries, a group of bright, young people was recruited.

Counting the department's senior managers who monitored the DRG project, 11 individuals can be identified as being central to the success of the effort. Only 1 individual is still with the department. Ten of the 11 persons left by 1982, before the DRG system was fully implemented and before the point at which any rate rebasing could occur to force improvements in hospital efficiency. One or two persons left because of a change in administrations brought about by the election of a Republican governor in 1981. Most left for better positions, including some that were out of state. Several established their own consulting firms, often acquiring clients from among the hospitals they had regulated.

The New Jersey DRG experiment attracted much attention within the health care industry from its very announcement. Everyone in the industry wanted to be better informed about the new approach to reimburse-

ment which was invariably described in the trade press as revolutionary. The project staff gained national visibility as experts in the DRG methodology. Invitations to lecture and write on DRGs were soon followed by job offers. When the actual implementation began, the pace of recruitment quickened. What was a threat to some, became an opportunity to others. If DRGs were to be the reimbursement standard of the future, then the industry needed its own experts or at least needed to own the experts.

Our evaluation examined the overall economic impact of DRG regulation and the effect on management.

Implementation in New Jersey lagged because the innovators were gone. One by one these innovators accepted the more challenging, better paying positions that they were offered—the career enhancing opportunities that could not be resisted. The innovators were better off, but the innovation was not. The regular staff, which was bypassed because it was not thought competent to initiate the DRG system, was left to oversee its implementation.¹⁴⁻¹⁵

In our society, the richest prizes go to those employed in the private sector, not the public sector.¹⁶ It is possible to assemble in state government a bright, vigorous team, but it is not possible to hold it together for very long. Intriguing proposals can be introduced. Persuasive plans can be announced and even initiated. But it is unlikely that there will be a staff in place that is capable enough or committed enough to see them through to fruition.

The federal government fares no differently. The first DRG-type reimbursement system, although it was not recognized as such in the Yale development, was in the federal Medicare program in 1972.¹⁷ In that year, Congress established the End Stage Renal Disease (ESRD) program as part of Medicare. In implementing the program, the federal government adopted a payment system to reimburse dialysis providers that foretold the DRG methodology. Fixed payments were made for each dialysis session to give incentive for efficiency. Over time the rates were to be ratcheted down to capture the gains and reduce government expenditures. But like DRGs, the promise of the payment system was better than the performance.

The cost of the program has soared since the early 1970s. What was once a \$200 million effort now is nearly \$2 billion. The program's cost growth is largely explained by increased patient enrollment as a prohibitively expensive treatment was made available to all who might benefit from it.¹⁸ But the costs increased also because the initial treatment prices, set high to encourage the provisions of services, were not adjusted for over a decade. Efficiency gains occurred, but federal taxpayers gained little from them.

Like that of the states, the federal government's administrative capacity is limited. The attention paid to the design of the ESRD program faded in its implementation as officials left or had their energies ab-

The federal government encouraged states to experiment with their own cost control programs. New Jersey was an early volunteer and received federal grants to implement the DRG system.

sorbed by other pressing problems. For years, it was unclear who within the supervising agency actually was in charge of the program. By the time the rates were addressed, millions of dollars in potential savings had been lost.¹⁹

The administrative weakness of government in American society does not explain fully the failure of reimbursement systems to constrain costs. Comparative analysis reveals that it is the conflict among governmental goals as much as the capacity to achieve any particular goal that limits the effectiveness of innovative reimbursement schemes.

A USEFUL COMPARISON

Cross national comparisons are common in health policy studies, foreign travel no doubt being the lure. The temptation is to compare Passaic with Paris and Camden with Copenhagen. But differences in political traditions, national culture, and structure of the health care systems—to cite only a few of the important variables—complicate the analysis. A more useful comparison is one between policy areas which would hold these contextual variables constant.

An appropriate comparison is with defense procurement.²⁰ Health and defense, in fact, share many characteristics. Both are technologically oriented policy areas; both are dominated by strong professions; both absorb enormous resources; and both are heavily dependent upon the private sector for the provision of government-financed services.

The reimbursement systems for defense contractors and hospitals are strikingly similar. Cost-based retrospective reimbursement, the system that prospective payment arrangements like DRGs replaced, is known in defense procurement as cost plus contracting and was used extensively during the 1940s and 1950s. Under its provisions, contractors were offered full cost reimbursement for the development of weapons plus a predetermined profit (the plus in cost plus contracting). Because weapons were under continual refinement, it became harder and harder to separate development from production efforts which were subject to the use of fixed price contracts. By the 1960s, the cost-generating problems of these contracting practices were obvious as was the failure of regulatory efforts to control the costs. Robert McNamara became Secretary of Defense in 1961 and instituted a series of procurement reforms, the most relevant feature of which was the requirement that incentive-type contracts be used where possible in place of cost reimbursement-type contracts.²¹ Incentive contracts resemble the outline of the DRG reform in that they offer contractors the opportunity to profit from cost savings, but also the risk of absorbing losses when costs exceed predetermined prices.

The results of the shift to incentive contracts were mixed. There were some cost savings, but not as much as advocates predicted.²² Incentive contracts and fixed

price arrangements, which also came into vogue again, had their own problems. Contractors cannot absorb very large losses nor can the government allow important contractors to make huge profits or to go out of business. When Lockheed was failing in part due to losses on its C-5A contract, the government provided the firm with a special loan. When General Dynamics threatened to default on its submarine construction contracts, the government made significant contract concessions. But let contractors make a lot of money, as occurred recently with spare parts purchasers, and a scandal results. Hearings are held and new laws are passed restricting potential profits. In the end though, the same contractors are busy making the same weapons. The military needs the weapons the contractors produce. Despite inefficiencies and scandals, the firms have to survive if national security is to be maintained. What cannot be tolerated are windfall profits or devastating losses no matter how persuasive the contracting logic.

Basically, the government was forced to realize that there are multiple, conflicting goals involved in defense contracting. Not only is there a desire for efficiency—cost control—but also a desire for high performance weapons produced as quickly as possible. In weapon acquisition jargon, there is a tradeoff among time, cost, and performance objectives. Accelerated delivery schedules and increased capabilities translate into increased costs. And, if cost dominates, then schedules and performances are likely to slip.

The parallel goals in health are cost control, quality, and access and there is a parallel lesson to be learned. Schemes like DRGs disappoint not only because we make government unattractive relative to private employment, but also because we want to preserve or increase access and quality. If the objective is simply to reduce costs, then the effect on access and quality could be ignored. Nearly always, however, there is pressure to improve both while reducing costs. If waste in the delivery of health care services was obvious then it might be possible to do this. But rarely will cost savings be achieved without at least a threat to access and quality. Conflicting goals limit the ability to reduce health care costs.

Finally, we need to recognize that politics pervades governmental activities. If Lockheed failed, thousands of workers in California, Georgia, and elsewhere in the nation would lose their jobs. If General Dynamics' Electric Boat division were to be put out of business, the economy of southeast Connecticut and southern Rhode Island would be severely disrupted. Similarly, in designing reimbursement programs, legislators and officials cannot ignore the effect on hospitals and health care professionals. No program can be pursued that will put all of the Catholic hospitals out of business or that would mean unemployment for half of the state's corps of nurses. There are political realities that temper the urge to reduce costs.

THE TECHNICAL LIMITATIONS

Lest some lament the constraints of politics, the technical limits of DRGs ought to be acknowledged. Tighter DRG prices could save money though perhaps at the cost of access for the needy and improvements in the quality of care. DRGs, however, are not a very effective device for managing hospital services.³

A major problem with the DRG system is that it does not adequately account for the full range of illness encountered. Included in the same DRGs are patients who differ significantly in the severity of their condition and in the cost of their treatment. DRG advocates claim that these severity differences average out and do not affect total reimbursement. They do not, however, average out within a hospital when individual physician profiles are being created. A few atypical cases can easily distort a physician's average for the entire year.

A major problem with the DRG system is that it does not adequately account for the full range of illness encountered; patients differ in severity of their condition and in treatment cost.

When the experience of high resource-using physicians is examined, another system problem is likely to be revealed. Unless an unusual amount is invested in computerized accounting procedures, it becomes quite difficult to sort out which physician actually is responsible for the costs. Difficult, expensive cases often require the collaboration of several physicians, surgeons as well as internists, even though the case may be listed only under the admitting physician or the senior surgeon. Residents may be ordering tests or drugs. Prolonged use of expensive, life-sustaining equipment may be needed. Consultants may be required. When something unusual happens in a hospital, responsibilities are likely to be shared.

To be sure, administrators still may want to collect expense data by physician, admitting or otherwise. The language of business has been absorbed into the hospital culture, producing an insatiable appetite for reports and frequent reference to terms such as strategic planning and product lines. But certain opposition from physicians makes it unlikely that the reports and rhetoric will lead to behavior change. So too do ethical considerations. Community obligations prevent the abandonment of many services. And few within the health care industry leap to be identified with decisions to refuse care because of costs or to manipulate treatment categories in order to gain higher reimbursements. DRG data may be wonderful to contemplate, but they are not guides to action.

CONCLUSIONS

New Jersey did accomplish much in its 1978 reform of hospital payment. It was one of the first states to ensure that hospital care would be available to all resi-

dents, and that hospitals that provided this care would not be bankrupted in the process. Those who finance care in the state have accepted a payment system that shares the burdens of paying for the uncompensated care equitably. Cost increases for hospital services have been limited to rates of growth that are less than national and regional experience and that are no worse than what was achieved under less inclusive reimbursement arrangements.

Despite its innovative design and its early promise the DRG component added little to the reform's overall accomplishments. The team assembled to guide the implementation of the DRG system found more challenging and lucrative opportunities before their task was completed. But even if they had remained in government, the team would not have been able to fulfill the expectations held for this new approach to hospital reimbursement. There are limitations inherent in any approach to reimbursement because of government's multiple and conflicting goals.

The producers of vital public services be they arsenals, weapon contractors, hospitals, or physicians, hold important policy leverage. In health care, cost containment efforts must be tempered by quality and access goals. The New Jersey reform recognized this requirement, the false promise of DRGs notwithstanding.

Although we continually search for panaceas, there are none. The federal government learned in defense that there is no simple or permanent solution to the problem of conflicting goals. So too will it learn in health care. The DRG payment system promises what cannot be achieved.

SUMMARY

New Jersey reformed its hospital reimbursement system in 1978, becoming the first state in the nation to use the Diagnosis Related Group (DRG) methodology for calculating payment rates.

The reform had significant benefits. Under its all-payer arrangements, access to hospital care for the state's residents and the financial viability of the state's hospitals serving the poor and uninsured was assured. Those who financed hospital care in New Jersey, and thus who provided the assured access and hospital income, had these burdens distributed in an equitable manner not possible in the preexisting reimbursement system. Health care costs continued on a trend that remained below national and regional experience.

The DRG component of the reform, however, did not fully achieve its objectives, especially as they related to the restructuring of managerial authority within hospitals. This was due, in part, to technical limits in the DRG methodology and to the early dispersion of the implementing team, most of whose members left for better paying and more challenging opportunities.

But the real obstacle to payment reform is the multiple and conflicting goals of health policy. Comparisons with defense procurement and the End Stage Renal Disease program demonstrate these limitations. Because government is concerned with access to services and the quality of care delivered, its cost control and system restructuring objectives will be constrained.

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SINGLE HIGH DOSE-LARGE FIELD IRRADIATION

ANDREW ZABLOW, M.D., R.J. STABILE, M.D., L.J. SANFILIPPO (M.D., LIVINGSTON*)

Between 1980 and 1985, 19 patients with symptomatic metastatic carcinoma were treated with single high dose-large field irradiation. Treatments were well tolerated and good pain relief was induced in 83 percent of patients with minimal acceptable side effects.

Symptomatic bone metastases are common problems facing the radiation oncologist. Radiotherapy is an effective treatment modality for local control, preventing further destruction, and, in many cases, promoting osteogenesis. Various studies have shown that radiotherapy achieves partial to complete response rates of 73 to 96 percent in patients treated for pain palliation.^{1,2} Palliation of pain and maintenance of structural support is the key to successful management in maintaining a good quality of life. Symptomatic patients require prompt attention and aggressive management to insure this quality of life.

Radiation therapy commonly is employed to palliate the symptoms of diffuse metastatic carcinoma. It effectively can relieve pain, alleviate obstruction, control hemorrhage, and improve function. Patients presenting with these symptoms require the immediate attention of the oncologist. Affording palliative relief is the oncologist's therapeutic challenge. Now that many lives are being extended by improved treatment modalities, pain is a very common complaint for the cancer patient.

Approximately 50 percent of all radiation treatments are given to palliate the symptoms of metastatic disease;³ these result from metastatic breast, prostate, or lung carcinoma.

For diffusely metastatic disease, single high dose-

large field irradiation (SHD-LFI) has been used extensively and effectively to combat the distressing symptoms of cancer-related pain. Some of the early work in hemibody irradiation was done over a half century ago.⁴ The proved effectiveness of palliative hemibody irradiation is well documented.^{4,6}

HISTORY

Due to their known radiosensitivity, hematologic malignancies were primarily treated during the 1960s. Cunningham began work with systemic radiotherapy.⁷ In the early 1970s, results were published on the use of whole and partial body radiotherapy for the control of advanced solid tumors.⁸ In the later 1970s, Fitzpatrick and Rider treated patients with sequential hemibody irradiation with doses ranging from 500-1,000 rads directed at one-half of the body;⁵ they based some of their early theories on the work of Court-Brown and Abbatt who charted the hematologic response of the body to total body irradiation.⁹ The radiation effect was most pronounced upon the white blood cells and platelets. By 28 days after radiation therapy, thrombocytopenia, lymphopenia, and granulocytopenia were the rule. Recovery was prompt and

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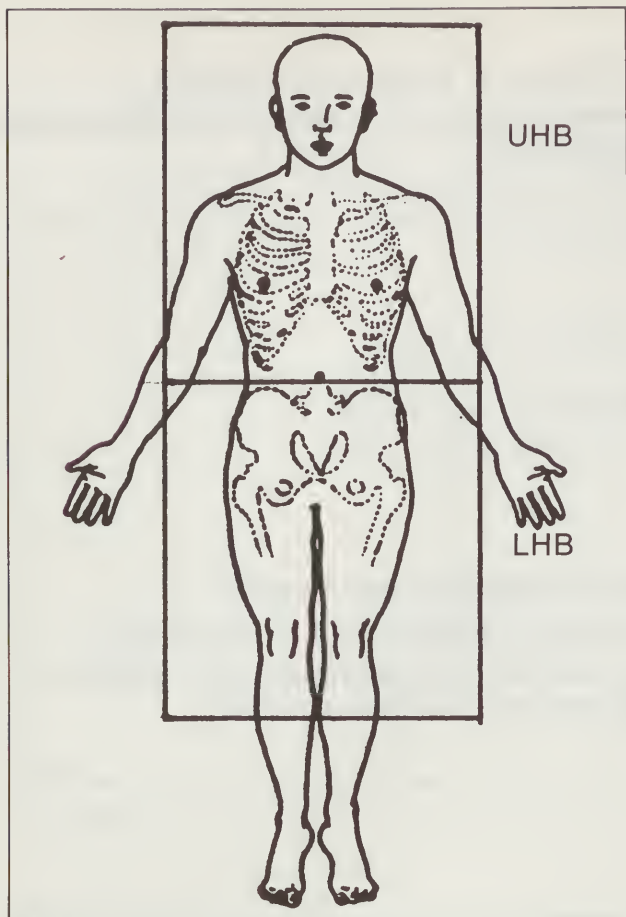


Figure 1—Limits of upper hemibody and lower hemibody fields.

practically complete by day 30 after radiotherapy. Normal pretreatment levels were seen by the following week.

Fitzpatrick found that by separating the upper hemibody and lower hemibody treatments by a latent period of at least 28 days, total body irradiation could be hematologically tolerated. Hemoglobin and platelet counts remained relatively constant while small fluctuations were seen in the total white cell count. They found the main limitation to upper hemibody radiation to be lung tolerance.⁴ This problem subsequently was examined by Salazar.¹⁰ This study found that single doses of 800 rads (uncorrected for lung transmission) caused a 10 to 20 percent incidence of fatal radiation pneumonitis. Correcting for lung transmission, doses of 600 rads are safely tolerated with minimal pulmonary toxicity.¹⁰

Protocols also were established for premedication programs to minimize "acute radiation syndrome" seen with upper hemibody irradiation.

SINGLE HIGH DOSE-LARGE FIELD IRRADIATION EXPERIENCE

From 1980 to 1985, we used single high dose-large field irradiation (SHD-LFI) to induce palliation in 19 patients with symptomatic metastatic carcinoma; these were advanced cases that had failed other conventional therapies. The patient population included 8 males and 11 females; the age range for males was 57 to 79 years and 40 to 68 years for females. The primary sites of disease included eight breast cases,

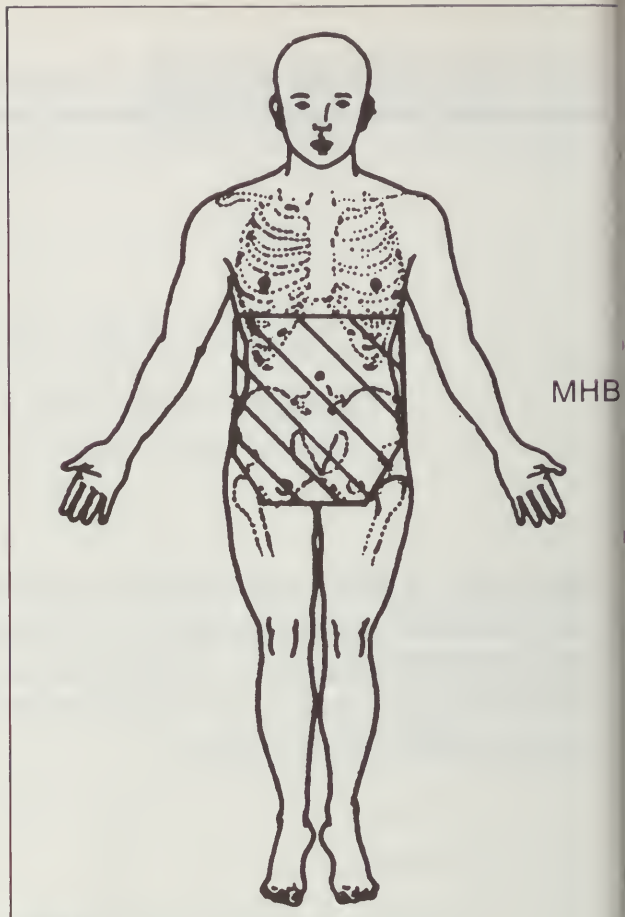


Figure 2—Limits of middle hemibody field.

seven prostate, and one each of lung, multiple myeloma, ovary, and epidermoid carcinoma of the skin. The upper hemibody (UHB) was irradiated in 8 patients the lower hemibody (LHB) was irradiated in 14 patients. This included 5 patients who also received UHE irradiation. Two patients received middle hemibody (MHB) irradiation which encompassed the abdomen and pelvis (Table 1).

Single doses of 600 to 1,000 rads were delivered at low dose rates of 25 to 40 rads per minute. The dose was delivered evenly through both anterior-posterior and posterior-anterior fields using an extended SSD of approximately 200 cm. All the patients were treated on a Clinac 18 utilizing 10 MeV photons. The limits of the fields are shown in Figures 1 and 2.

When treating the UHB, certain procedures were followed: 24-hour hospitalization for the actual procedure followed by a weekly check-up and complete blood count for the first two months and monthly follow-up thereafter; blocking the parotid glands, eyes, and previously treated fields; corrections for lung transmission; calculating a treatment gap as needed; and premedication program (Table 2).

Side effects of the treatments included nausea, fatigue, and diarrhea; others are shown in Table 3.

RESULTS

In our experience, we were able to produce good palliative pain relief in 83 percent of the patients treated. This usually was dramatically seen within the first 24 to 48 hours post-treatment. In two patients,

we saw progressive reduction in the size of tumor masses and visceral enlargement.

The hemibody radiotherapy is well tolerated by the patients and, in most cases, provides effective prolonged symptomatic relief. The side effects are transient in nature, respond to conservative management, and appear to be tolerable. The hematological toxicity is minimal and safe. The CBC and platelet counts return to pretreatment levels within six to eight weeks after the procedure.

TABLE 1 Fields Treated		
Field	Patients	
Upper Hemibody (UHB)	8	
Lower Hemibody (LHB)	14	5 patients received UHB and LHB
Middle Hemibody (MHB)	2	
Total:	24*	

*6 with previous chemotherapy, 14 with previous local radiotherapy, and 9 with previous hormonal radiotherapy

TABLE 2 Premedication Program	
A. Prednisone, 10 mg orally, four times a day.	
B. Torecan 2 cc intramuscularly on call to radiotherapy, then every 4 hours as needed post-radiotherapy.	
C. 1,000 cc etc. prior to radiotherapy.	
D. Nothing by mouth 6 hours pre-radiotherapy.	
E. RT = radiotherapy; IV = intravenously.	
F. Vital signs every hour for 12 hours post-radiotherapy, then every four hours.	

SHD-LFI appears to be a highly effective treatment for advanced metastatic disease that has failed conventional modalities. We found good symptomatic relief in 20 out of 24 patients treated. This included 2 patients who had relief secondary to dramatic shrinkage of tumor mass involving viscera (Table 4).

If we separate the patients by site of disease, we found that 90 percent of the breast and prostate patients had good relief. In the other diseases treated, we saw 50 percent of patients had good relief. Table 5 shows the response to treatment by tumor site.

With SHD-LFI, treatment of several involved areas with metastatic disease can be encompassed into one treatment session, whereas conventional therapy requires several treatment sites and multiple treatment fractions. The ease of delivering the treatment and its effectiveness is well recognized by those utilizing it and those being treated. This is in contrast to the more protracted treatments which usually provide good palliation but are very tedious to the patient.

The average length of life after treatment was 4.5 months with a range of one-half to ten months. Two patients still are alive with disease. The great majority of patients who showed good symptomatic relief following treatment had continued relief for the remainder of their lives. Two patients continued to experience pain within the treatment field; additional radiother-

TABLE 3 Side Effects	
Effect	Patients
Nausea and Vomiting	7
Fatigue	6
Diarrhea	6
Epilation	2
Xerostomia	1
Anorexia	3
Tenesmus/Cramps	2
Fever and Septic Shock	1
Leukopenia	3
Thrombocytopenia	4

TABLE 4 Breast and Prostate	
	Patients
Good Relief	18
Minimal/None	2
Total:	20

Others	
Good	2
Minimal/None	2
Total:	4

TABLE 5 Response By Tumor Type			
	Good	Minimal	None
Prostate	8		1
Breast	10	1	
Lung	1		
Ovary		1	
Multiple Myeloma	1		
Epidermoid		1	
Total:	20	3	1

apy was given to the small symptomatic areas and afforded good pain control.

CONCLUSIONS

SHD-LFI is an effective short-term treatment for multiple sites of disease. SHD-LFI achieves good, enduring pain palliation that usually is dramatically seen within 24 to 48 hours. SHD-LFI can cause regression in the size of tumor masses, visceral and nodal enlargement, and concomitantly offers relief from the symptoms associated with these masses. SHD-LFI is well tolerated with minimal toxicity experienced by the patients. Modified SHD-LFI can be utilized in patients previously treated with local radiotherapy and/or chemotherapy.

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LEFT LATERAL INTERNAL SPHINCTEROTOMY FOR ANAL FISSURE—AS AN OFFICE PROCEDURE

LEWIS D. ZINKIN, (M.D., EAST BRUNSWICK*)

Patients with anal fissures seek prompt diagnosis and treatment for a painful condition. Although the left lateral internal sphincterotomy has been accepted, it usually has been done for chronic fissures and in the hospital surgical suite. The author advocates a simplified method of internal sphincterotomy as an office procedure.

Anal fissure is a common anorectal disorder seen by primary care physicians, gastroenterologists, and general and colo-rectal surgeons. It causes considerable pain and disability for the patient and should be diagnosed easily and accurately. Prompt treatment will minimize suffering.

Although the technique of lateral internal sphincterotomy generally has been accepted as the preferable treatment for chronic anal fissure,^{1,2} it often is considered a hospital procedure and then only for the chronic phase of the condition. The inherent disadvantages of this approach, in terms of cost and time, should be considered. This paper demonstrates the technique of lateral internal sphincterotomy as an office procedure and advocates its more liberal use.

TECHNIQUE

The patient is placed in the prone jack-knife position or the left lateral Sims position. The buttocks can be taped apart to facilitate exposure. A local anesthetic, such as lidocaine 2 percent or bupivacaine 0.5 percent with 1:200,000 epinephrine, is used to infiltrate the left lateral perianal area with some infiltration extending to the anterior and posterior midline (Figure 1). The injection is the only painful part of the procedure and the patient, when forewarned, generally can tolerate it quite well.

A small incision (radial or concentric) is made over the intersphincteric groove. The anodermal tissue is elevated off the internal sphincter up to the dentate margin by scissor dissection (Figure 2). No anal retractor is necessary. The intersphincteric plane is likewise developed. The "isolated" internal sphincter, with its easily identifiable whitish muscle fibers, is grasped with a straight hemostat and sharply cut (Figure 3). Hemostasis is achieved by electrocoagulation and/or direct pressure. No sutures are used. The small incision is left open. A simple dressing then is applied. The procedure takes five to ten minutes to perform.

Wound care consists of warm sitz baths, moist baby-wipe tissues for anal hygiene, an antibiotic ointment to the wound, and a simple dressing gauze cover. The wound closes rapidly within a few days. One post-operative visit after two weeks usually is all that is necessary.

RESULTS

Charts of 163 patients seen from January 1980 to January 1986, who were diagnosed as having an anal

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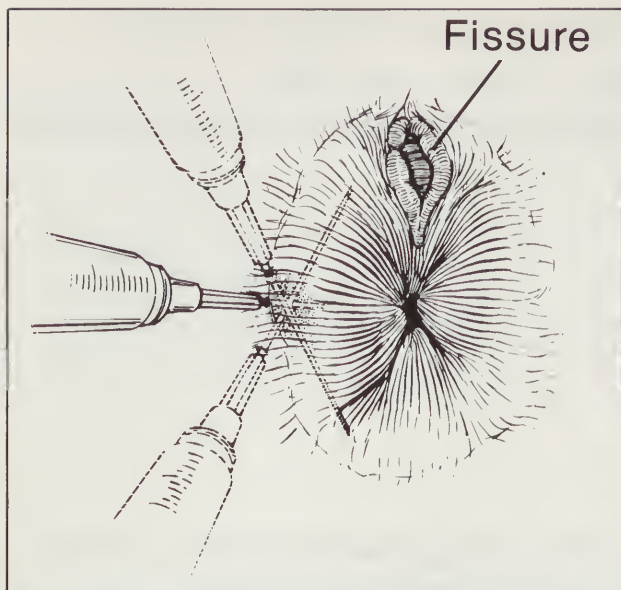


Figure 1—Local anesthesia is injected into the left perianal tissue with some extension to the anterior and posterior midlines.

fissure, were reviewed. Of these, 76 patients were considered as having an acute fissure, i.e. their symptoms were occurring for the first time and were less than three weeks in duration, and 87 patients had a chronic fissure; the latter group had recurrent symptoms or symptoms occurring for the first time, but present for greater than three weeks.

Of the 163 patients with an anal fissure, 29 patients were treated initially by conservative therapy, i.e. stool softeners, topical anesthetics, sitz baths. Of the 29 patients treated conservatively, 17 patients came to surgery for recurrent symptoms. The remaining 134 patients were treated by a left lateral internal sphincterotomy as the initial treatment. Only 4 of these procedures had to be performed in the hospital either for specific medical needs, e.g. antibiotic prophylaxis for a patient with mitral valve prolapse, or a strong patient preference or anxiety.

Of the 151 patients who underwent left lateral internal sphincterotomy, 94.7 percent showed prompt healing of the fissure and immediate relief of pain due to spasm. Analgesics were rarely needed by the second day after the procedure. The only complication was infection at the sphincterotomy site in 5.3 percent of the patients. Infection presented as a perianal abscess or, more commonly, as purulent drainage through the wound. Even in those patients with wound infection, the pain of the fissure had resolved. Patients in this group who developed infection were treated by simple re-opening of the wound (2 patients) or fistulotomy (6 patients).

DISCUSSION

Anal fissures affect a large number of people. Physicians who see patients in any outpatient facility should be aware of the typical symptoms and findings associated with a fissure. A fissure has a typical pattern of pain which is initiated by a bowel evacuation and lingers up to several hours. Studies have shown that the pain of a fissure is caused by spasm of the internal sphincter.^{3,4} Whether this hypertonicity of the

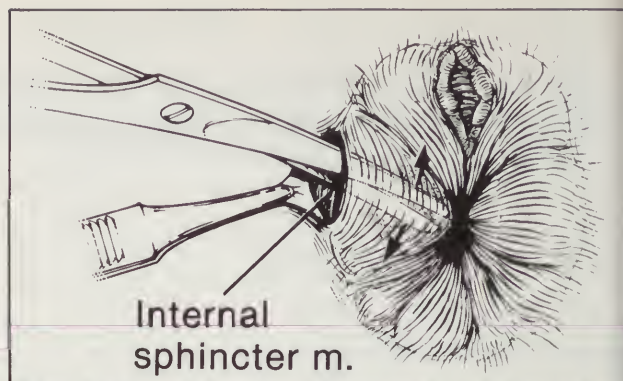


Figure 2—A small 5 mm incision is made and the anoderm is dissected off the internal sphincter up to the dentate margin. The intersphincteric space behind the sphincter is likewise freed.

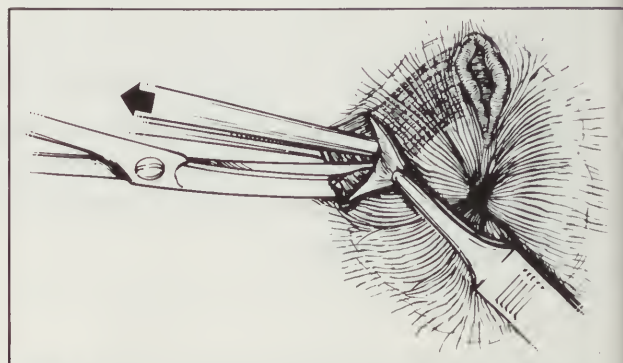


Figure 3—The internal sphincter is grasped and sharply cut.

sphincter is cause or effect is uncertain, however, until the spasm is relieved, the fissure will continue.

This concept of the internal sphincter being the underlying perpetuating factor is what accounts for the success of the sphincterotomy. Initially, the procedure was done in the posterior midline, right through the exposed bed of the fissure. However, this approach has been largely abandoned because of the problems with poor healing.⁵ In its place, the lateral sphincterotomy has become increasingly popular.

When a patient appears with the typical symptoms of severe, intermittent anal pain and the findings of an anal fissure (usually present in the posterior midline and sometimes in the anterior midline), a decision needs to be made as to therapy. Conservative therapy usually consists of stool softeners, warm sitz baths, and a topical anesthetic/steroid cream. Shub and colleagues reported a cure rate of 44 percent with conservative therapy within a four-to-eight-week period.⁶ Although a similar cure rate for acute fissures was seen in this series (12 of the 29 patients treated), the fact that failure of therapy was more likely and that, even when successful, the length of time suffering was longer, made this approach less appealing. Furthermore, the chance for cure of a chronic fissure by conservative therapy is even less.

I have taken a more aggressive approach in the treatment of fissures and have treated most patients with a left lateral internal sphincterotomy as an initial therapy. The main advantages of this approach are the almost immediate relief of pain and the prompt healing of the fissure. One of the disadvantages has been that most physicians have felt it necessary to perform

this procedure within the hospital. This entails the delays inherent in hospital scheduling. The patient must continue to be in pain while a mutually convenient time is set for surgery. Furthermore, even if the procedure is done on an ambulatory basis or in a one-day surgery unit, the hospital costs are considerable, ranging from \$500 to \$1500. If an anesthesiologist is present, common for in-hospital procedures, an additional fee must be considered. In this era of fiscal responsibility in health care, these factors and costs should be of concern for the medical practitioner.

SUMMARY

Anal fissure is a common anorectal problem. Patients are in considerable pain and seek prompt relief. The left lateral internal sphincterotomy has been shown to be an effective method of achieving prompt relief of pain and rapid healing of the fissure. The

technique, as described, is done easily and in the office, thus eliminating the unnecessary delay and costs associated with in-hospital surgery.

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CASE REPORT: DISSECTING ASCENDING AORTIC ANEURYSM IN PUERPERIUM

AMRIT P. NAYAR, M.D., AND DUANE G. SOSSONG, D.O., CHERRY HILL*

We illustrate the necessity of considering aortic dissection in the differential diagnosis of chest pain in the postpartum patient. Symptoms of chest pain should be a signal for prompt evaluation. Aggressive diagnostic and therapeutic approach should be taken to alter the outcome of this potentially fatal problem.

Dissecting aortic aneurysms are known to be associated with pregnancy. The incidence of dissecting aortic aneurysms in the postpartum period has not been as well discussed in the literature. The following is a case report of a patient who developed dissecting ascending aortic aneurysm 16 days after parturition. The patient underwent successful surgical repair and is doing well 15 months postoperatively.

CASE REPORT

A 22-year-old black female, gravida 3, para 2, had a normal vaginal delivery on September 25, 1985. She appeared in the emergency room on October 11, 1985, with a chief complaint of retrosternal pain, described as moderate pressure sensation which began two hours prior to admission. There was no radiation of pain, nausea, vomiting, or diaphoresis. She had a short episode of chest pain which was felt to be musculoskeletal in origin in the first postpartum day. An electrocardiogram at that time was normal. Her past medical history was significant for a heart murmur of undetermined etiology since age 14, and she was not taking any medications prior to the admission; family history was unremarkable.

The physical examination revealed blood pressure 150/70 and pulse 96/minute. The cardiac examination was significant for a grade III/VI systolic ejection

murmur heard best over the right sternal border and a grade III/VI decrescendo diastolic murmur heard best over the left sternal border. The lungs were clear on auscultation. The peripheral pulses were intact and blood pressures were obtained.

The laboratory results were as follows: white blood cell count of 11.3; hemoglobin of 13.3 gm/dl; hematocrit 39.2 percent; serum sodium 140 mg/dl; serum chloride 107 mg/dl; bicarbonate 27 meq/l; blood sugar 103 mg/dl; BUN 12 mg/dl; serum creatinine 0.9 mg/dl; amylase 57 units; and CPK 135 units. Electrocardiogram was normal with sinus tachycardia. Radiologic evaluation of the chest demonstrated widened mediastinum (Figure 1). A diagnosis of ascending aortic dissection was entertained and confirmed with cardiac catheterization and aortogram (Figure 2).

The patient was taken to the operating room for an emergency sternotomy. Findings included 150 cc sanguinous pericardial effusion. There was a moderately large aneurysm of the ascending aorta measuring 7 cm in transverse diameter, with ecchymosis. There was an oblique tear extending along the posterior two-thirds of the circumference of the ascending aorta just above

*From the Department of Cardiac Surgery, Our Lady of Lourdes Medical Center, Camden. Correspondence may be addressed to Dr. Nayar, 1245 Brace Road, Cherry Hill, NJ 08034.



Figure 1—Chest x-ray of our patient showing widening of the mediastinum.

the left main coronary ostium. The aortic valve was bileaflet. Patient underwent excision and replacement of aortic valve and ascending aorta with #25 Bjork Shiley composite graft valve conduit and coronary implantation.

The hospital postoperative course was satisfactory and uneventful; the patient was discharged on postoperative day 12. Pathology report revealed unremarkable aortic valve and no pathologic evidence in the aortic wall.

DISCUSSION

About 50 percent of aortic dissections in women younger than 40 years of age are associated with pregnancy.^{1,3} By far, most dissections in pregnancy occur during the third trimester⁴ and are relatively rare during labor. When reviewing the literature of dissecting aortic aneurysms during the postpartum period, only 15 cases could be identified.^{2,4,5} Previous reports of dissecting aortic aneurysms successfully treated during pregnancy using surgical techniques have been reported in the literature.⁷⁻⁹ Unfortunately, in the vast majority of cases, the diagnosis is made late in the clinical course; this accounts for the high mortality. Prior to the 1950s, most cases were diagnosed at autopsy. Death occurred in 78 percent due to secondary rupture into the pericardium.⁶

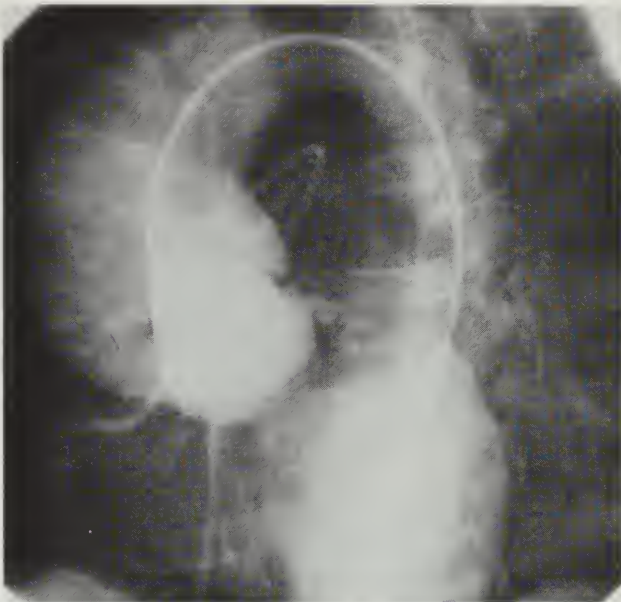


Figure 2—Cineangiogram showing dissecting ascending aortic aneurysm with intimal flap and aortic regurgitation.

Our patient was mildly hypertensive; hypertension was present only in approximately half of reported cases.² Pedowitz et al. stated that hypertension is not a predisposing factor.⁴ Our patient did not have any evidence of coarctation of the aorta or any connective tissue disorder, though bicuspid aortic valve was present. This may be seen in one-third of the cases.⁵ The presenting symptoms were consistent with angina and not the typical ‘tearing’ pains associated with a dissecting aneurysm.

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6/82 9/82 12/82 3/83

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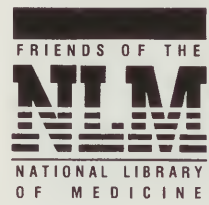


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†See Warnings and Precautions.

Please see brief summary of prescribing information on the next page.

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Brief Summary

Professional Use Information

CARDIZEM[®]
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CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

- Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
- Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
- Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
- Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies,

oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Coronogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in *in vitro* bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be of least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

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- | | |
|-------------------|---|
| Cardiovascular: | Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope. |
| Nervous System: | Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor. |
| Gastrointestinal: | Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase. |
| Dermatologic: | Petechiae, pruritus, photosensitivity, urticaria. |
| Other: | Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarthralgia pain, polyuria, sexual difficulties. |

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 9/86

See complete Professional Use Information before prescribing.

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DOCTORS' NOTEBOOK

**Trustees' Minutes; UMDNJ
Notes; MSNJ Auxiliary;
New Members; Physicians
Seeking Location in
New Jersey**

Trustees' Minutes November 15, 1987

A regular meeting of the Board of Trustees was held on November 15, 1987, at the Executive Offices in Lawrenceville. A detailed report is on file with the secretary of your county society. A summary of significant actions follows:

Report of the President . . .

(1) **Task Force on AIDS** . . . Noted that Leon G. Smith, M.D., will serve as the chairman of the newly formed Task Force on AIDS.

(2) **Insurance Carrier Performance of Utilization Review** . . . Noted that performance of utilization review in hospitals by insurance carriers was one of the issues discussed at the meeting with Commissioner of Health Coye and Commissioner of Insurance Merin.

Report of Executive Director . . .

(1) **MSNJ Paid Membership** . . . Was advised that there has been no significant change in the number of paid memberships over the past four years; noted that a report on dues-exempt members will be com-

pleted by the Committee on Long-Range Planning and Development.

(2) **MSNJ Financial Statements** . . . Approved the financial statements for the periods ending August 31, 1987, and September 30, 1987.

(3) **State Commission of Investigation on Medical Discipline and Licensing in New Jersey** . . . Approved the following recommendation:

That the Executive Committee be authorized to monitor closely the Impaired Physicians Program on an ongoing basis; to respond to the press and legislature as the need arises; and to retain special legal counsel.

Also, referred the following two recommendations to the Executive Committee:

(1) That the name of the Impaired Physicians Program be changed to the "Physicians Assistance Program."

(2) That the Board authorize the employment of an additional physician, counselor, and secretary for the Impaired Physicians Program.

(4) **New Jersey State Medical Underwriters, Inc.** . . .

(a) **1988 Rates and Classification (MIENJ)** . . . Was advised that the New Jersey State Medical Underwriters insurance rates for 1988 will be the same as for the current year and the 1978 dividend will be increased from 10 to 11 percent.

(5) **Litigation** . . .

(a) **Wilk Case** . . . Heard that the Federal Court has determined the AMA did discriminate against chiropractors; hence, the AMA might be required to publish the District Court injunctive order in one issue of JAMA.

(b) **Insurance Department Plan for Medical Malpractice** . . . Received as information the MSNJ comments regarding the Insurance Department Medical Insurance Performance Program sent to Commissioner Merin.

(c) **Third-Party Interference** . . . Noted that a meeting with the Insurance Commissioner has been scheduled to discuss complaints by attending physicians regarding pre-admission authorizations required by third-party carriers.

(d) **Hospital Licensing Standard Reform Project** . . . Noted that MSNJ is cooperating with the New Jersey Department of Health by mailing survey questionnaires to selected physicians with a request

for their expert opinions concerning a reform of hospital licensing standards.

UMDNJ Report . . .

(1) **AIDS-Related Research** . . . Heard that UMDNJ received three multimillion dollar grants from the National Institutes of Health for AIDS-related research.

(2) **Site Visit by Liaison Committee on Medical Education** . . . Note that the Robert Wood Johnson Medical School received high marks from the Liaison Committee on Medical Education.

(3) **AMA Visits Medical School** . . . Noted the AMA will have one-day visits to both medical schools in spring 1988, and may include representatives of MSNJ.

(4) **Test of Clinical Skills To Be a Certification Requirement** . . . Noted that UMDNJ's Board of Trustees voted to include a test of clinical skills as part of the medical school examination process beginning in 1989.

(5) **Doctor Formica To Serve on Search Committee** . . . Heard that Doctor Formica will represent MSNJ on the search committee being assembled to select a new dean for the Robert Wood Johnson Medical School.

NJ Hospital Association . . .

(1) **DRGs** . . . Noted that M. Scibetta defined DRGs, from the hospitals' perspective, as a mechanism for allocating costs, and indicated the hospital system is being jeopardized by lack of money; the NJHA focus is on monetary rather than regulatory concerns.

(2) **Nursing Shortage** . . . Note that the Hospital Rate-Setting Commission acceded to NJHA's request for an immediate 2 percent adjustment to the labor component of the economic factor, a temporary measure to run through December 31, 1987; the purpose was to eliminate deficits resulting from past salary increases for nurses.

Council on Medical Services . . .

(1) **Medallion Plan** . . . Approved unanimously the following recommendation:

(1) That the Society reject the proposal to advise the Society's membership that it is in their best interest to consider rejecting "participating" status in Blue Shield; and in its place, a balanced pro-

sentation in a general fact sheet format be released to assist the membership in rendering their own individual decisions regarding participation.

Also, the following recommendation was unanimously approved as amended:

(2) That the Board be advised that the Council is opposed to the concept of differential/discriminatory reimbursements for identical services rendered whether a physician is participating or not, and saw no legal remedy possible.

Also, the following recommendation was approved:

(3) That the Board seek an independent legal opinion to determine whether the Blue Shield position that Pace-participants also are participants in the Medicaid is valid.

Finally, the following recommendation was unanimously approved:

(4) That the Board should further explore the January 1980 directive by past Insurance Commissioner Sheeran, directing Blue Shield to include its membership of participating physicians in all their programs, and that if it is found that the directive requires Blue Shield to do this, legislative or administrative relief should be sought.

(2) Resolution #30E: Uniform National Standards of Care . . . Unanimously approved as amended the following recommendation:

That because of the the thousands of variables, uniform standards of care cannot be formulated at this time by our Society.

Council on Public Relations . . .

(1) Resolution #14: Free Choice of Physicians . . . Noted that a new advertisement, "Health Care Options: They're Enough To Make You Dizzy," was published in daily newspapers on August 27, 1987.

(2) Resolution #20: MSNJ Public Relations Activities . . . Noted that the Council is planning implementation of this Resolution calling for an all-out public relations effort.

(3) Substitute Resolution #24: Public Relations Sponsorship with Connecticut, Delaware, New York, and Pennsylvania . . . Noted that the other four state societies had an unfavorable response to this Resolution and no further action is contemplated.

(4) Special Assessment . . . Noted that a second mailing has been sent to members concerning the special assessment mandated by the House of Delegates to fund activities of the Council on Public Relations.

Committee on Publication . . .

(1) Disclaimer for Advertisements . . . Approved with editorial corrections the following recommendation:

That the following advertising disclaimer appear on the masthead of *NEW JERSEY MEDICINE*: "The appearance of advertising in *NEW JERSEY MEDICINE* is not a Medical Society of New Jersey guarantee or endorsement of the product or service, or the claims made for the product or service, by the advertiser. When the Medical Society of New Jersey has endorsed a product or program, that will be expressly noted."

(2) Committee Minutes . . . Requested copies of the minutes of meetings of the Committee on Publication and requested the chairman of the Committee to attend Board meetings when there is a report from his Committee.

(3) Graphics/Photographs in NEW JERSEY MEDICINE . . . Advised by Mr. Maressa that he has delayed consideration of the issue of graphics in the computer operations of MSNJ.

(4) Membership Newsletter . . . Approved a motion which directs the Board to advise the Committee on Publication that the Membership Newsletter is the responsibility of the executive staff of the Medical Society of New Jersey.

Committee on Senior Citizens . . . Approved the following recommendation:

That the Board of Trustees request each county medical society to appoint a representative to the Committee on Senior Citizens.

MEDICAL SOCIETY OF NEW JERSEY ANNUAL MEETING

April 27-May 1, 1988
Sheraton Meadowlands Hotel
East Rutherford

Proposed Daily Schedule

Wednesday, April 27, 1988

3:30 p.m.—Board of Trustees' Meeting

Thursday, April 28, 1988

9:00 a.m.—Registration Opens

9:00 a.m.—Message Center Opens

2:00 p.m.—House of Delegates

3:30 p.m.—Reference Committees

Friday, April 29, 1988

8:00 a.m.—Registration Opens

8:00 a.m.—Message Center Opens

8:30 a.m.—Exhibits Open

9:00 a.m.—House of Delegates (election)

12:00 noon—Golden Merit Award Ceremony followed by Reception

2:30 p.m.—Reference Committees

5:00 p.m.—JEMPAC Political Forum

5:45 p.m.—JEMPAC Wine and Cheese Reception

Saturday, April 30, 1988

8:00 a.m.—Registration Opens

8:00 a.m.—Message Center Opens

8:30 a.m.—Exhibits Open

9:00 a.m.—House of Delegates

1:30 p.m.—House of Delegates

6:00 p.m.—Inaugural Reception followed by Inaugural Dinner

Sunday, May 1, 1988

8:00 a.m.—Registration Opens

8:00 a.m.—Message Center Opens

8:30 a.m.—Program on one topic of major interest to the physician

1:00 p.m.—Board of Trustees' Meeting

Unfinished Business . . .

(1) Membership Roster . . . Noted Doctor Cherashore's suggestion that a list of MSNJ members in each hospital be made available to those physicians on each hospital medical staff willing to match that list with a current list of physicians on their staff; this effort is directed to increasing membership.

(2) Medical Malpractice Reinsurance Association Deficit . . . Noted that the Commissioner of Insurance is close to making a decision on how to handle the medical malpractice deficit of \$40 million; MSNJ members will be advised of all actions.

(3) Tort Reform . . . Noted that the Senate Judiciary Committee has indicated that the tort reform bills will be on the agenda of their next meeting or the one immediately following.

(4) Moment of Silence . . . Observed a moment of silence in tribute to the memory of Mr. Richard I. Nevin, former Executive Director of MSNJ, who died on October 28, 1987.

Correspondence . . .

(1) MAAC Program . . . Received and noted information from the AMA stating that their Board of Trustees drafted legislation to seek repeal of the MAAC (maximum allowable actual charge) and the participating physician program.

(2) Nursing Shortage . . . Received and noted correspondence from the Commissioner of Health indicating the Departments of Health and Insurance have convened a study group to review the various factors contributing to the nursing shortage.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.

During the past year, UMDNJ has undertaken an intensive effort to identify what it will need to do to meet Governor Kean's challenge to become one of the nation's top 25 health sciences universities by the turn of the century.

Until the beginning of this decade the characteristics of a top-ranked health sciences center were clear-cut: an excellent educational program, an extensive, well-funded research program, and a prestigious teaching hospital offering a com-

plete range of sophisticated specialized services. While these factors still are of major importance, economic and social trends dictate that academic health centers also must be prepared to excel within a new set of criteria, if they are to survive and thrive in the 21st century.

Participation in the development of a sound and comprehensive system for providing health services to the poor and the aged has emerged as a critical factor for a leading health science university. The institutions that attain top ranking will be those which can establish themselves as the core of a balanced, stable regional health care system. With the health industry's increasing emphasis on cost containment and competition, this will require taking a leadership role in developing the systems and mechanisms for providing adequate services to the needy. New initiatives begun by UMDNJ in 1987 include:

- With a \$600,000 grant from the Robert Wood Johnson Foundation, UMDNJ-New Jersey Medical School opened the first school-based health clinic for teenagers at Newark's Barringer High School. In addition, University Hospital's Maternal and Infant Care program collaborated with the Urban League of Essex County to establish a prenatal clinic for

pregnant teenagers at the Chestnut Street School.

- UMDNJ-School of Osteopathic Medicine established a program to track the effects of environmental hazards on pregnant women.

- UMDNJ-New Jersey Dental School launched a program with the Newark Board of Education to provide regular dental checkups to elementary school children.

- UMDNJ took on the operation of the ambulance service for the City of Camden as an extension of its University Hospital Emergency Medical Services in Newark.

- UMDNJ-Community Mental Health Center at Piscataway initiated the Student Assistance Program to provide drug and alcohol abuse counseling to students at Middlesex County high schools.

- The Eric B. Chandler Health Center was opened in New Brunswick by UMDNJ-Robert Wood Johnson Medical School and its core hospital to provide community-based family care to local residents.

All of the elements New Jersey needs for urban redevelopment—improved educational systems, development of new housing, and stimulation of new business ventures—are dependent upon adequate health care systems within the cities to ensure a healthy urban

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Category: (Please check one)

☐ Member, MSNJ

☐ Subscriber, NJ Medicine

☐ Other _____

Name _____

Old Address _____

City _____ State _____ Zip _____

New Address _____

City _____ State _____ Zip _____

environment and a strong, productive workforce. UMDNJ will continue to work with state and local agencies to play a role in the development of a comprehensive health care system to serve New Jersey's cities.

MSNJ Auxiliary

Mrs. Sally Ilagan

In this age of medical practice crisis, we no longer can be apathetic toward government intervention in the practice of medicine. Everything you and I do affects what the government imposes upon medicine today. The bureaucracy is taking away your rights on how to treat your patients.

Medical malpractice insurance still is on the rise and putting some specialties out of practice.

In reading these statements you probably are saying, "What is she telling me, that I don't already know?" That may be true, but what are you and your spouse attempting to do about the situation? You no longer can say you don't have the



photo: Mrs. Donald E. Sly

time. As a medical family, you must make the time.

One of the first things we all can do is happily participate in membership in the Medical Society of New Jersey and the Auxiliary. Power is in numbers. We can be our own public relations. Persuade the younger

physicians and spouses what continued membership in both societies can accomplish. We must use all that we have in our power to improve the image of the medical family.

Don't be one of the persons depicted in the photograph. Let us keep our heads out of the sand and face reality.

Get the message to your spouse. We have something to offer and your spouse has expertise to offer the Auxiliary. Impress upon your spouse the importance of membership—active and passive. The practice you save may be your own.

Don't hesitate. Call the Medical Society of New Jersey Auxiliary at 609/896-1766.

**CANDIDATES FOR
MSNJ OFFICES**

If you are interested in becoming an Officer, Trustee, or member of the AMA Delegation, a new opportunity exists for you.

The Nominating Committee will meet several times this year to consider candidates. We will consider members other than those recommended by county medical societies and nominating delegates for any of these offices.

If you wish to be considered, please contact your county medical society or the Medical Society of New Jersey for the necessary forms.

This is a real opportunity for grassroots candidate development and we urge you to use it.

New Members

The Medical Society of New Jersey would like to welcome the following new members:

Atlantic County

Bassel B. Ibrahim, M.D., Absecon
Steven E. Kornberg, M.D., Northfield
Kelly M. Reid, M.D., Somers Point

Bergen County

Valerio Bariletti, M.D., Ridgewood
Benjamin R. Dispenziere, M.D.,
Wayne
David L. Feit, M.D., Bronx, NY
Eric L. Fremed, M.D., Teaneck
Ronald M. Glassman, M.D., Monsey
Patricia K. Joseph, M.D., Fort Lee
Ronley H. Plous, M.D., New York, NY
Anne R. Summers, M.D., Ramsey
Andrew J. Tashjian, M.D., River Edge
Fred A. Wolodiger, M.D., Englewood

Burlington County

Joseph V. Attewell, M.D., Marlton
Arnold M. Baskies, M.D., Willingboro
Douglas D. Bradley, M.D.,
Mount Holly
David C. Lee, M.D., Mount Laurel
Robert C. Messey, M.D., Willingboro
Jeffrey Myers, M.D., Mount Holly

Camden County

James W. Bush, M.D., Cherry Hill
Joseph J. Fanelle, M.D., Bellmawr
Thomas D. Guastavino, M.D.,
Hammonton
Cynthia A. Marqueen, M.D., Camden

Amrit P. Nayar, M.D., Cherry Hill
Harvey A. Snyder, M.D., Audubon
Mary A. Willard, M.D., Voorhees

Cape May County

Robert J. Weiss, M.D., Cape May
Court House

Essex County

Douglas Ashendorf, M.D.,
Springfield
Alvin Bell, M.D., Montclair
Edward S. Eisenberg, M.D.,
Montclair
David A. Fein, M.D., Livingston
Gary R. Marecek, M.D., West Orange

Donato Marucci, M.D., Belleville
Michael A. Meese, M.D., Nutley
John E. Robinton, M.D., Montclair
Joseph C. Segen, M.D.,
East Brunswick
Paul N. Servidio, M.D., Montclair
Shrenik G. Shah, M.D., Bloomfield
Marca L. Sipski, M.D., West Orange
Bartholomew J. Tortella, M.D.,
Jersey City
Steven J. Weiss, M.D., Livingston
Laurence Wynn, M.D., West Caldwell

Gloucester County

David A. Bundens, M.D., Woodbury

Hudson County

Merle C. Cruz, M.D., Jersey City
Vinod R. Lala, M.D., Jersey City
Mariananda P. Kumar, M.D.,
Jersey City

Hunterdon County

Randy S. Klein, M.D., Clinton

Mercer County

Scott L. Adler, M.D., Lawrenceville
Michael S. Beede, M.D.,
Lawrenceville
Robert M. Cherrey, D.O., Trenton
Robert B. Coutant, M.D., Edison
Joel C. (Molly) Coye, M.D., Trenton
James P. Larsen, M.D., Trenton
Rosemary H. LoCastro, M.D.,
Trenton
Jonathan B. McCabe, M.D.,
Princeton
Evan S. Morrison, M.D., Princeton
John Pennacchi, M.D., Trenton

Middlesex County

Bonna G. Benjamin, M.D.,
New Brunswick
Richard B. Bullock, M.D., Edison
Norman H. Edelman, M.D.,
New Brunswick
Joseph W. Gaffney, M.D.,
New Brunswick
Steven C. Goldberg, M.D.,
East Brunswick
Irwin A. Keller, M.D., East Brunswick
Shahid Latif, M.D., Edison
Ronald Lau, M.D., Edison
Thomas W. Loew, M.D., Spotswood
David L. Mandelbaum, M.D.,
New Brunswick
Darron J. Molter, M.D.,
New Brunswick
Donato A. Panaligan, M.D.,
Old Bridge
Arthur W. Perry, M.D., Somerset
Arthur M. Pirone, M.D.,
New Brunswick

MEDICAL SOCIETY OF NEW JERSEY ANNUAL MEETING

April 27-May 1, 1988

**Sheraton Meadowlands Hotel
East Rutherford**

Proposed Daily Schedule

Wednesday, April 27, 1988

3:30 p.m.—Board of Trustees' Meeting

Thursday, April 28, 1988

9:00 a.m.—Registration Opens
9:00 a.m.—Message Center Opens
2:00 p.m.—House of Delegates
3:30 p.m.—Reference Committees

Friday, April 29, 1988

8:00 a.m.—Registration Opens
8:00 a.m.—Message Center Opens
8:30 a.m.—Exhibits Open
9:00 a.m.—House of Delegates (election)
12:00 noon—Golden Merit Award Ceremony followed by Reception
2:30 p.m.—Reference Committees
5:00 p.m.—JEMPAC Political Forum
5:45 p.m.—JEMPAC Wine and Cheese Reception

Saturday, April 30, 1988

8:00 a.m.—Registration Opens
8:00 a.m.—Message Center Opens
8:30 a.m.—Exhibits Open
9:00 a.m.—House of Delegates
1:30 p.m.—House of Delegates
6:00 p.m.—Inaugural Reception followed by Inaugural Dinner

Sunday, May 1, 1988

8:00 a.m.—Registration Opens
8:00 a.m.—Message Center Opens
8:30 a.m.—Program on one topic of major interest to the physician
1:00 p.m.—Board of Trustees' Meeting

MSNJ 222nd Annual Meeting

**Sheraton Meadowlands Hotel
East Rutherford, NJ**

David H. Schaer, M.D.,
North Brunswick
Frederick Sheer, M.D., Cranbury

Monmouth County

William E. Cohen, M.D., Freehold
Michael J. Disciglio, M.D.,
Long Branch
Richard L. Eiges, D.O., Morganville
Leslie L. Herskowitz, M.D., Freehold
Jeffrey J. Larkin, M.D., Wanamassa
Peter C. Mandel, M.D., Matawan
Michael S. Markoff, M.D., Keansburg
Bong S. Rhee, M.D., Red Bank
Michael W. Stark, M.D., Morganville
Richard C. Tarvers, M.D.,
New Brunswick
Benjamin Weinstein, M.D.,
Englishtown
August L. Wreiole, M.D.,
Long Branch
Frank J. Vozos, M.D., Ocean
Alan R. Zbik, M.D. Manalapan

Morris County

Donald T. Allegra, M.D., Randolph
Anita M. Bhambhani, M.D.,
Morristown
Thomas A. Giangrosso, M.D.,
Succasunna
Bruce M. Neckritz, D.O.,
Mount Tabor
John M. O'Neal, M.D., Orange

Ocean County

Lalitha Gopalakrishnan, M.D.,
Jackson
Mahadevan Gopalakrishnan, M.D.,
Jackson
Kevin T. McManus, M.D., Lakewood
Arthur M. Molina, M.D., Lakewood
Flavius M. Thompson, M.D.,
Lakewood

Passaic County

Richard S. Morski, M.D., Oakland
Geraldine I. Nelson, M.D., Wayne
John W. Scott, M.D., Paterson
Theresa A. Soroko, M.D., Clifton
Kevin E. Vitting, M.D., Clifton

Somerset County

Robert A. Benigno, M.D., Somerville
Gene F. Uhler, M.D.,
South Bound Brook

Union County

Daryl K. Boffard, M.D., Union
Jane E. Brown, M.D., Springfield
Jong-Il Choi, M.D., West Orange
Celia M. Fernandez-Botelho, M.D.,
Elizabeth
Ramon A. Fernandez-Ledon, M.D.,
Roselle
Steven B. Shukan, M.D., Elizabeth

Geraldine M. Summa, M.D.,
Watchung

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Daniel O'Brien, M.D., 12 Beech Dr., Brunswick, ME 04011. Liege (Belgium) 1975. Board certified. Group, partnership, solo. Available.

ENDOCRINOLOGY—Alex Stewart Stagnaro-Green, M.D., 228 Voorhis Ave., River Edge, NJ 07661. Mount Sinai 1983. Also, internal medicine. Board eligible. Board certified (IM). Partnership, group, solo. Available July 1988.

FAMILY MEDICINE—William B. Glenn, D.O., 2 Raintree Way, Havelock, NC 28532. Philadelphia College 1980. Board certified. Group, partnership, solo. Available July 1988.

GASTROENTEROLOGY—Joel H. Kurtz, M.D., 2600 Netherland Ave., Apt. 2811, Riverdale, NY 10463. UMDNJ 1983. Board eligible. Partnership or group. Available July 1988.

HEMATOLOGY—Marta Meyers, M.D., 128 Hempstead Ct., Madison, NJ 07940. Medical College of Pennsylvania 1981. Also, internal medicine. Board certified. Group or partnership. Available.

INTERNAL MEDICINE—Robert P. Beswick, M.D., 2316 W. Cortez St., Chicago, IL 60622. Illinois 1981. Board certified. Group, partnership, clinic, industry. Available.

Glenn A. Dubov, M.D., 75-36 Bell Blvd., Apt. 2A, Bayside, NY 11364. Chicago 1983. Board certified. Also, nephrology. Group or partnership. Available July 1988.

Kathy Rosen Kerr, M.D., 318 Perrine Ave., Piscataway, NJ 08854. UMDNJ 1984. Also, pediatrics. Board eligible. Partnership or small group. Available July 1988.

Daniel R. Massarelli, M.D., 98 Longfellow Rd., Worcester, MA 01602. Georgetown 1985. Board eligible. Group, partnership, solo. Available September 1988.

Marta Meyers, M.D., 128 Hempstead Ct., Madison, NJ 07940. Medical College of Pennsylvania 1981. Also, hematology. Board certified. Group or partnership. Available.

Leilani L. Nixon, M.D., 1175 Gail Dr.,

Buffalo Grove, IL 60089. Illinois 1985. Board eligible. Partnership or solo. Available July 1988.

Sarva Daman Singh, M.D., 26 Carlson Ct., Closter, NJ 07624. Agra (India) 1978. Board eligible. Group or partnership. Available March 1988.

Samuel J. Stepanow, M.D., 430 W. Browning Rd., Apt. S-5, Bellmawr, NJ 08031. Hahnemann 1985. Board eligible. Group or partnership. Available July 1988.

Darius Sypek, M.D., 154 Oakwood Ave., Apt. 3, Cliffside Park, NJ 07019. Medical Academy (Poland) 1984. Board eligible. Group. Available July 1988.

Alex Stewart Stagnaro-Green, M.D., 228 Voorhis Ave., River Edge, NJ 07661. Mount Sinai 1983. Also, endocrinology. Board certified. Board eligible (ENDOCRIN). Partnership, group, solo. Available July 1988.

NEPHROLOGY—Glenn A. Dubov, M.D., 75-36 Bell Blvd., Bayside, NY 11364. Chicago 1983. Also, internal medicine. Board certified (IM). Group or partnership. Available July 1988.

OPHTHALMOLOGY—James Scott Lewis, M.D., 531 Sprague Rd., Narberth, PA 19072. Jefferson 1982. Group, partnership, solo. Available.

ORTHOPEDIC SURGERY—Richard Lebovitz, M.D., 707 Abbott St., Highland Park, NJ 08904. Downstate 1979. Board eligible. Partnership or solo. Available.

PEDIATRICS—Sheth Amit, M.D., 1305 E. 18 St., Brooklyn, NY 11230. N.H.L. Municipal (India) 1982. Board eligible. Group, partnership, solo. Available July 1988.

Meera Gupta, M.D., 57 Lawrence Dr., Berkeley Heights, NJ 07922. Nehru Medical College (India) 1977. Board eligible. Group or partnership. Available.

Kathy Rosen Kerr, M.D., 318 Perrine Ave., Piscataway, NJ 08854. UMDNJ 1984. Also, internal medicine. Board eligible. Partnership or small group. Available July 1988.

RADIOLOGY—Charles Saniewski, M.D., 9261 E. Bay Harbor Dr., #8, Bay Harbor, FL 33154. Rome 1983. Board eligible. Group or partnership. Available July 1988.

SURGERY—Victor B. Lebedovych, M.D., 211 S. Crapo St., Mt. Pleasant, MI. Michigan 1968. Board certified. Partnership or association. Available.

Ramiro Requena, M.D., Interfaith Medical Center, 555 Prospect Place, Brooklyn, NY 11238. Bolivia 1966. Board certified. Group, partnership, solo. Available.

UROLOGY—Charles Dorfman, M.D., 3313 Amherst Rd., Erie, PA 16506. Universidad Central del Este (Mexico) 1980. Board eligible. Group or partnership. Available July 1988.

NINTH ANNUAL MINIRESIDENCY IN OCCUPATIONAL MEDICINE

UNIVERSITY OF MEDICINE AND
DENTISTRY OF NEW JERSEY

DEPT. OF ENVIRONMENTAL AND COMMUNITY MEDICINE
ROBERT WOOD JOHNSON MEDICAL SCHOOL
PISCATAWAY, NEW JERSEY 08854

DATE:

May 2-20, 1988/15 weekdays/8:30 a.m.-4:30 p.m.,
6 evening classes/6:30-8:30 p.m.

PURPOSE:

To provide a comprehensive review of key concepts in Occupational Medicine given by eminent specialists from university, government and industry. To aid in obtaining board eligibility and certification.

ACCREDITATION:

The University of Medicine and Dentistry of New Jersey-Office of Continuing Education certifies that this continuing medical education activity meets the criteria for 90 hours of credit in Category I for the Physician's Recognition Award of the American Medical Association, provided the program is completed as designed.

SUBJECTS:

Industrial Hygiene, Occupational Disease, Toxicology, Practice of Occupational Medicine, Epidemiology and Biostatistics, Ergonomics, Public Health Administration.

INQUIRIES: Patricia Reid (201) 463-4707
UMDNJ-Office of Continuing Education
675 Hoes Lane, Piscataway, N.J. 08854-5635

THE ACADEMY OF MEDICINE OF NEW JERSEY
in cooperation with
THE MEDICAL COLLEGE OF PENNSYLVANIA
&
THE PHILADELPHIA GERIATRIC CENTER
presents

THE CHALLENGE OF THE GERIATRIC PATIENT: A CLINICAL APPROACH

on
WEDNESDAY, FEBRUARY 24, 1988
9:30 A.M.-4:15 P.M.

at
TRUMP PLAZA HOTEL AND CASINO
ATLANTIC CITY, NEW JERSEY

GOALS:

This symposium is designed to:

- Provide a context in which clinicians can think differently about preventative health and medical problems of the elderly.
- Provide new information that will be helpful in the diagnosis and management of diseases in the elderly.

OBJECTIVE:

- Participants will be able to integrate new developments in geriatrics with their current knowledge to manage their elderly patients more effectively.

JOEL POSNER, M.D.

Symposium Chairman

Medical Director, Philadelphia Geriatric Center

Associate Professor of Medicine

Chief, Division of Geriatrics

Medical College of Pennsylvania

For further information on Registration, Faculty and Fees,

Please Contact:

Dana R. Davies

Academy of Medicine of New Jersey

Two Princess Road, Lawrenceville, New Jersey 08648
(609) 896-1717

ANNUAL CME ASSEMBLY

presented by the

MEDICAL SOCIETY OF THE STATE OF NEW YORK

New Approaches to Habit Abuse and Dependency

APRIL 22-24, 1988

THE NEW YORK HILTON, NEW YORK CITY

HIGHLIGHTS . . .

25 CME Sessions; Panel Discussions; 80 Technical Exhibits; two Receptions; President's Dinner Dance.

Registration: There is a \$25. fee for members of the New Jersey State Medical Society; no fee for residents, medical students, or medical assistants. Non-member physicians—\$50; Allied Professions \$10. We are accredited by the Accreditation Council for CME.

For a copy of the preliminary program, contact: MSSNY, 420 Lakeville Road, P.O. Box 5404, Lake Success, N.Y. 11042.

Attn: Meeting Services

(516) 488-6100

MARCH-NOVEMBER 1988 TUES. EVES. 4:30-7:30 p.m.



EMERGENCY MEDICINE BOARD REVIEW #312

TUITION: \$1500

Accreditation: 60 AMA Category I credit hours.

Pending: 60 AAFP and ACEP credit hours.

For New York metropolitan area physicians: Weekly 3-hour sessions spread over a 22 week period to prepare for the written portion (Part I) of the Emergency Medicine Board Examination, plus a 2-hour ("1 on 1") patient management encounter session for each registrant that simulates and prepares candidates for the oral portion (Part II) of the Board Examinations.

Information available on #315 EMERGENCY MEDICINE, June 13-17, 1988 Monday-Friday

For Further Information:

NYU POST-GRADUATE MEDICAL SCHOOL

550 First Avenue, New York, N.Y. 10016

(212) 340-5295 (24-hour service)

MSNJ 1/88

The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization for further information.

This list is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, The Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of UMDNJ. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

February

- 6 **Eighth Annual Clinical Anesthesia**
8 A.M.—4:30 P.M.—New Jersey Medical School, MSB, B-552, Newark (UMDNJ)

March

- 2 **Does Choice of Anesthetic Make a Difference?**
8-8:50 A.M.—Robert Wood Johnson Medical School, MEB-593, New Brunswick (UMDNJ)
- 12-13 **29th Annual Postgraduate Anesthesia Seminar**
Hyatt Hotel, Cherry Hill (New Jersey State Society of Anesthesiologists)

CARDIOLOGY

February

- 1 **Advanced Cardiac Life Support**
- 2 **Provider Course**
- 4 New Jersey Medical School, MSB,
- 29 B-648, Newark (UMDNJ)
- 17 **Antiarrhythmic Drugs, VPCs—When To Treat**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth (Alexian Brothers Hospital)

March

- 1 **Advanced Cardiac Life Support**

- 3 **Provider Course**
- 28 New Jersey Medical School, MSB,
- 29 B-648, Newark
- 31 (UMDNJ)
- 17 **New Approaches to the Management of Heart Failure**
5 P.M.—Fuld Auditorium, Somerset Medical Center, Somerville (Somerset Medical Center)

DERMATOLOGY

February

- 9 **Dermatology Lecture**
8-10 P.M.—Schering Corporation, Kenilworth (The Dermatological Society of New Jersey)
- 17 **Dermatology Conferences**
6-9 P.M.—Rutgers Community Health Plan, 57 U.S. Highway 1, New Brunswick (UMDNJ)

March

- 8 **Dermatology Lecture**
8-10 P.M.—Schering Corporation, Kenilworth (The Dermatological Society of New Jersey)
- 16 **Dermatology-I**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth (Alexian Brothers Hospital)
- 16 **Dermatology Conferences**
6-9 P.M.—Rutgers Community Health Plan, 57 U.S. Highway 1, New Brunswick (UMDNJ)
- 23 **Dermatology-II**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth (Alexian Brothers Hospital)
- 30 **Common Skin Disorders**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth (Alexian Brothers Hospital)

MEDICINE

February

- 1 **Rheumatology Staff Conference**
5:30-7 P.M.—Robert Wood Johnson Medical School, MEB-393, New Brunswick (UMDNJ)
- 3 **Other Sexually Transmitted Diseases**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth (Alexian Brothers Hospital)
- 3 **Monthly Dinner Meeting**
6-9 P.M.—Holiday Inn, Newark Airport (AMNJ)

- 3 **Medical Grand Rounds, Endocrine Series**
- 10 11:30-1 P.M.—VA Medical Center,
- 17 East Orange (AMNJ)
- 24 3 **Interhospital Endocrine Conferences**
10 3:30-5 P.M.—Rotates between Newark Beth Israel Medical Center, University Hospital, VA Medical Center, and United Hospitals Medical Center (UMDNJ)

- 4 **Genetic Toxicology, From Theory to Practice**
4-6 P.M.—Coriell Institute, Camden (Coriell Institute)
- 8 **Arthritis**
7-8 P.M.—Wallkill Valley General Hospital, Sussex (AMNJ)
- 8 **Abnormal Liver Function, Tests and Their Meaning**
2-3 P.M.—Forensic Psychiatric Hospital, Trenton (Forensic Psychiatric Hospital)
- 10 **Medical Grand Rounds**
- 17 10 A.M.—St. Mary Hospital,
- 24 Hoboken (St. Mary Hospital)
- 10 **Calcium Metabolism**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove (AMNJ)
- 10 **Dinner Meeting: NJ Gastroenterological Society**
6:30 P.M.—Parsippany Hilton (NJ Gastroenterological Society)
- 10 **Seizures**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth (Alexian Brothers Hospital)
- 16 **Regional Nephrology Conference Series**
4-5 P.M.—Robert Wood Johnson Medical School, MEB, New Brunswick (UMDNJ)
- 18 **Family Practice Conference**
- 29 12 noon—St. Mary Hospital, Hoboken (St. Mary Hospital)
- 18 **Laser Treatment of GI Hemorrhage and GI Carcinomas**
2-3 P.M.—John E. Runnells Hospital of Union County, Berkeley Heights (AMNJ)

- 19-21 **Allergy and Nutrition**
Sheraton, Orlando, Florida (Holy Name Hospital)
- 24 **New Drugs and Therapeutic Choices in HTN**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth (Alexian Brothers Hospital)
- 25 **Benzene Metabolism and Effects**
4-6 P.M.—Coriell Institute, Camden (Coriell Institute)
- 25 **Chronic Pain Management and Issues Related to Iatrogenic Addiction**
3-4 P.M.—Ancora Psychiatric Hospital, Hammonton (AMNJ)

March

- 2 **Drug Addiction: Chronic Pain Management and Other Issues**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic (St. Mary's Hospital)
- 2 **Drug Interactions**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth (Alexian Brothers Hospital)
- 3 **Disease Associated with Exposure to Asbestos**
4-6 P.M.—Coriell Institute, Camden

THE PHILADELPHIA HEART INSTITUTE
of Presbyterian-University of Pennsylvania Medical Center

CARDIOLOGY UPDATE ...

designed for the Physician and provides an intensive survey of the
current status of Clinical Cardiology ...

WEDNESDAY

FEBRUARY 3, 1988

3:00 to 5:00 PM

DIAGNOSIS AND MANAGEMENT OF CORONARY
HEART DISEASE: SPECIFIC SYNDROMES

MODERATOR: BERNARD L. SEGAL, M.D.

3:00-3:20	Silent myocardial ischemia	Robert Katz, M.D.
3:20-3:40	Coronary spasm	Norman Feinsmith, M.D.
3:40-4:00	Unstable angina	Jan R. Weber, M.D.
4:00-4:30	Case presentations	Howard Noveck, M.D.
4:30-5:00	Panel discussion	Joel A. Krackow, M.D.; Michael S. Feldman, M.D.

- No Registration Fee
- No Advance Registration Required
- CME Credits*

* * Refreshments Served Following Each Session * *

Scheie Eye Institute Auditorium
Presbyterian-University of Pennsylvania
Medical Center
39th and Market Streets
Philadelphia, Pennsylvania

Parking Available (at discount rate.)

*The University of Pennsylvania School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing education for physicians. The University of Pennsylvania School of Medicine designates this continuing medical activity for 2 credit hours per session in Category 1 of the Physician's Recognition Award of the American Medical Association.

(Coriell Institute)

- 5 Endocrine Series**
11:30 A.M.-1 P.M.—VA Medical Center, East Orange (AMNJ)
- 7 Rheumatology Staff Conference**
5:30-7 P.M.—Robert Wood Johnson Medical School, MEB-393, New Brunswick (UMDNJ)
- 8 Laser Treatment of GI Hemorrhage**
12 noon-1 P.M.—Hospital Center at Orange (AMNJ)
- 9 Medical Grand Rounds**
10 A.M.—St. Mary Hospital, Hoboken (St. Mary Hospital)
- 9 Management of Abdominal Emergencies**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic (St. Mary's Hospital)
- 10 Scientific Meeting**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston (New Jersey Institute of Ultrasound in Medicine)
- 16 Nephrotoxicity of Common Drugs**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic (AMNJ)
- 17 Indoor Air Pollution: Public Health Perspective**
4-6 P.M.—Coriell Institute, Camden (Coriell Institute)
- 17 Physical Assessment of Severely Disabled**
1:30-2:30 P.M.—Vineland Developmental Center Hospital (AMNJ)
- 17-36th Annual Convention:**
- 20 Family Practice**
Bally's Park Casino Hotel, Atlantic City
- 18 Gastroenterology—Peptic Ulcer**
10:30-11:30 P.M.—Woodbridge Developmental Center (AMNJ)
- 24 Radon: Consequences of Human Exposure**
4-6 P.M.—Coriell Institute, Camden (Coriell Institute)
- 24 Proper Use of Antibiotics**
1:30-2:30 P.M.—Hunterdon Developmental Center, Clinton (AMNJ)

NEUROLOGY

February

- 3 Alzheimer's Disease**
10-11 A.M.—Green Brook Regional Center (AMNJ)

March

- 9 Alzheimer's Disease**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove (AMNJ)

OBSTETRICS/GYNECOLOGY

February

- 21-Obstetrics/Gynecology Update**
26 Topnotch at Stowe, Vermont (UMDNJ)

- 25-Annual Semmelweis-Waters**
- 27 Ob/Gyn Conference**
Resorts International Hotel, Atlantic City (UMDNJ)

ONCOLOGY

February

- 1 Hematology/Oncology Conference**
12 noon-1 P.M.—Robert Wood Johnson Medical School, MEB-108A, New Brunswick (UMDNJ)
- 2 Prostate Cancer**
7-8 P.M.—West Hudson Hospital, Kearny (West Hudson Hospital)
- 3 Scientific Dinner Meeting**
17 6:30-9:30 P.M.—The Manor, West Orange (AMNJ)
- 4 Tumor Board Conferences**
11 9-11 A.M.—Irvington General Hospital (Irvington General Hospital)
- 18 18**
- 25 25**
- 4 Genetic Toxicology**
4-6 P.M.—Coriell Institute, Camden (Coriell Institute)
- 5 Cancer Research Colloquium**
12 12 noon-1:15 P.M.—New Jersey Medical School, MSB, G-506a, Newark (UMDNJ)
- 9 Renal Biopsy Conferences**
12:30-2 P.M.—Barnert Memorial Hospital Center, Paterson (Barnert Memorial Hospital Center)
- 11 Carcinogens and Anticarcinogens**
4-6 P.M.—Coriell Institute, Camden (Coriell Institute)
- 17 Lung Cancer**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic (AMNJ)
- 18 Differential Repair of Active and Inactive Genes in Mammalian Systems**
4-6 P.M.—Coriell Institute, Camden (Coriell Institute)
- 18 Early Bladder Carcinoma—Management of Carcinoma in Situ and Small Lesions**
5-6:30 P.M.—Fuld Auditorium, Somerset Medical Center, Somerville (Somerset Medical Center)
- 25 Tumor Board Conferences**
12 noon—Newcomb Medical Center, Vineland (Newcomb Medical Center)
- 25 Benzene Metabolism and Effects**
4-6 P.M.—Coriell Institute, Camden (Coriell Institute)

March

- 2 Scientific Dinner Meeting**
16 6:30-9:30 P.M.—The Manor, West Orange (AMNJ)
- 30 30**
- 3 Tumor Board Conferences**
10 9-11 A.M.—Irvington General Hospital (Irvington General Hospital)
- 24 24**
- 31 31**
- 4 Cancer Research Colloquium**

- 11 12 noon-1:15 P.M.—New Jersey Medical School, MSB, G-506a, Newark (UMDNJ)**

Hematology/Oncology Conference

- 21 21**
12 noon-1 P.M.—Robert Wood Johnson Medical School, MEB-108A, New Brunswick (UMDNJ)
- 9 Ninth Annual Tumor Board Conference**
6-9 P.M.—MSNJ Headquarters, Lawrenceville (The Oncology Society of New Jersey)
- 10 Studies on the Mechanism of Action of 2, 3, 7, and 8—Tetrachlorodibenzo-P-Dioxin: Receptor-Mediated Toxicity**
4-6 P.M.—Coriell Institute, Camden (Coriell Institute)
- 24 Tumor Board Conferences**
12 noon—Newcomb Medical Center, Vineland (Newcomb Medical Center)

ORTHOPEDICS

February

- 3 Biomechanics of the Spine**
10:30-11:30 A.M.—Christ Hospital, Jersey City (AMNJ)

PATHOLOGY

February

- 2 Renal Pathology Conference**
12 noon-1 P.M.—Robert Wood Johnson Medical School, New Brunswick (UMDNJ)
- 3 Pathology of Hemodialysis Patients**
10:30-11:30 A.M.—Christ Hospital, Jersey City (AMNJ)

March

- 1 Renal Pathology Conference**
12 noon-1 P.M.—Robert Wood Johnson Medical School, New Brunswick (UMDNJ)

PEDIATRICS

February

- 2 Case Conferences**
9 8-9 A.M.—Robert Wood Johnson Medical School, MEB-108A, New Brunswick (UMDNJ)
- 16 16**
- 23 23**
- 4 Pediatric Grand Rounds**
11 8:30-9:30 A.M.—Robert Wood Johnson Medical School, MEB-102, New Brunswick (UMDNJ)
- 18 18**
- 25 25**
- 5 Pediatric Infectious Diseases Rounds**
12 9-10 A.M.—Rotates between Newark Beth Israel Medical Center, St. Joseph's Medical Center, and Children's Hospital (UMDNJ)
- 19 19**
- 26 26**
- 5 Advances in Pediatrics**
12 9:30-10:30 A.M.—New Jersey Medical School, MSB, B-610, Newark (UMDNJ)



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- 26 Management of Multiple Trauma in Children**
8 A.M.-12 noon—Overlook Hospital, Summit
(Overlook Hospital)
- March**
- 4 Advances in Pediatrics**
11 9:30-10:30 A.M.—New Jersey Medical School, MSB, B-610, Newark
(UMDNJ)
- 8 Case Conferences**
15 8-9 A.M.—Robert Wood Johnson Medical School, MEB-108A, New Brunswick
(UMDNJ)
- 3 Pediatric Grand Rounds**
10 8:30-9:30 P.M.—Robert Wood Johnson Medical School, MEB-102, New Brunswick
(UMDNJ)
- 31 (UMDNJ)**
- PSYCHIATRY**
- February**
- 1 Case Presentations**
8:15-10:15 P.M.—call for information
(Essex Psychiatric Seminars)
- 4 Case Seminars**
18 8-10 P.M.—312 Harding Drive, South Orange
(Advanced Psychiatric Study Group)
- 8 Panic Attacks in a Postpartum Depressed Woman**
8:15-10:15 A.M.—For information, call 201-777-3724
(Essex Psychiatric Seminars)
- 9 Early Office Recognition of Depression**
12 noon-1 P.M.—Hospital Center at Orange
(AMNJ)
- 18 Scientific Meeting**
Saint Barnabas Medical Center
(NJ Psychoanalytic Society)
- 25 Chronic Pain Management and Issues Related to Iatrogenic Addiction**
3-4 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)
- March**
- 3 Developmental Disabilities**
10-11 A.M.—Green Brook Regional Center
(AMNJ)
- 5 Case Seminars**
19 8-10 P.M.—312 Harding Drive, South Orange
(Advanced Psychiatric Study Group)
- 18 Treatment of Insomnia**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth
(Alexian Brothers Hospital)
- 19 Scientific Meeting**
Saint Barnabas Medical Center
(NJ Psychoanalytic Society)
- 19 Clinical Issues in Human Sexuality—An Update on Drugs, Diseases, and Devices**
5-6:30 P.M.—Fuld Auditorium, Somerset Medical Center, Somerville
(Somerset Medical Center)
- 25 Depression in the Elderly**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth
(Alexian Brothers Hospital)
- RADIOLOGY**
- February**
- 18 Scientific Meeting**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(AMNJ)
- March**
- 10 Scientific Meeting**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(New Jersey Institute of Ultrasound in Medicine)
- 16 Dinner Meeting**
6:30-9:30 P.M.—The Manor, West Orange
(Radiation Oncology-AMNJ)
- SURGERY AND SURGICAL SPECIALTIES**
- February**
- 1 Surgical Grand Rounds**
8 3:30-5:30 A.M.—New Jersey Medical School, MSB, B-610, Newark
(UMDNJ)
- 15 School, MSB, B-610, Newark (UMDNJ)**
- 22 (UMDNJ)**
- 29**
- 6 Surgical Treatment of Cardiothoracic Diseases**
10-11:30 A.M.—New Jersey Medical School, MSB, G-506, Newark
(UMDNJ)
- 6 Morbidity and Mortality Conference**
8 8:30-10 A.M.—New Jersey Medical School, MSB, B-610, Newark
(UMDNJ)
- 13 School, MSB, B-610, Newark (UMDNJ)**
- 15 School, MSB, B-610, Newark (UMDNJ)**
- 20 (UMDNJ)**
- 22**
- 27**
- 29**
- 10 Plastic and Reconstructive Surgery**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)
- 17 Surgical Conference**
11 A.M.—St. Mary Hospital, Hoboken
(St. Mary Hospital)
- 23 Peripheral Vascular Disease**
8-10 P.M.—The Englewood Club, 115 E. Palisade Avenue, Englewood
(Englewood Surgical Society)
- March**
- 5 Surgical Treatment of Cardiothoracic Diseases**
10-11:30 A.M.—New Jersey Medical School, MSB, G-506, Newark
(UMDNJ)
- 5 Morbidity and Mortality Conference**
7 8:30-10 A.M.—New Jersey Medical School, MSB, B-610, Newark
(UMDNJ)
- 12 School, MSB, B-610, Newark (UMDNJ)**
- 14 (UMDNJ)**
- 21**
- 26**
- 28**
- 7 Surgical Grand Rounds**
14 4:30-5:30 P.M.—New Jersey Medical School, MSB, B-610, Newark
(UMDNJ)
- 21 School, MSB, B-610, Newark (UMDNJ)**
- 28 (UMDNJ)**
- 9 Vascular Diseases in the Elderly**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth
(Alexian Brothers Hospital)
- 16 Surgical Conference**
11 A.M.—St. Mary Hospital, Hoboken
(St. Mary Hospital)
- 16 Annual Clinical Abstract**
10:30-11:30 A.M.—Newark Beth Israel Medical Center
(Vascular Society of New Jersey)
- 22 Treatment of Renal Calculi with the Lithotripter**
8-10 P.M.—Englewood Club, 115 E. Palisade Avenue, Englewood
(Englewood Surgical Society)
- 30 Ninth Annual Vascular Symposium**
8 A.M.-5 P.M.—New Jersey Medical School, MSB, B-552, Newark
(UMDNJ)
- UROLOGY**
- February**
- 1 Urology Grand Rounds**
Robert Wood Johnson Medical School, MEB-108B, New Brunswick
(UMDNJ)
- 2 Prostate Cancer**
7-8 P.M.—West Hudson Hospital, Kearny
(West Hudson Hospital)
- March**
- 1 Urology Grand Rounds**
Robert Wood Johnson Medical School, MEB-108B, New Brunswick
(UMDNJ)

The AIDS Controversy

AIDS Vaccine, Testing for AIDS

November 3, 1987

Dear Doctor Krosnick:

The article by Dr. Leon G. Smith and Mr. Richard E. Brennan, Esq., "AIDS Vaccine," in the October 1987 issue of *NEW JERSEY MEDICINE* is well written, and with the points made, follows a logical conclusion. However, it is a classic example of how an erroneous logical conclusion can be arrived at by false or only partially true premises and by omitting important information.

The authors' final conclusion is that inoculation against AIDS must be carried out on a nationwide basis. Their own modifier, however, dictates against this conclusion. I quote, "However, it would be appropriate to exempt those persons who show reasonable certainty that vaccination would seriously impair their well-being or cause their deaths."

Vaccines that have been tried and tested for years, such as small pox and DPT, are not without their liability and risk. Need I remind these individuals of the minor crisis that was created a few short years ago when DPT was in short supply because drug manufacturers ceased production of this vaccine because of liability?

The authors are proposing that the entire population be exposed to a vaccine with limited knowledge of

its potential complications and side effects. The authors are ignoring the fact that despite extensive testings, before releasing a drug or vaccination, the FDA requires years of widespread use in order for all complications and consequences to be revealed.

Mr. Brennan sites many court decisions supporting the premise that the state has an interest and a right in protecting the general health and safety of its citizens, collectively and individually. I find fault with the argument, however, that the constitutional rights of the majority of the citizens must be compromised to preserve the constitutional rights of the individuals in those few subgroups who are at high risk.

As of this date, there is no evidence to support the fact that AIDS can be transmitted via casual contact, and for this reason, I support the authors' contention that these people should not be isolated or ostracized from society. However, the fact remains that AIDS is transmitted by sexual and direct blood contact. I contend that the disease can be contained if these people modify their sexual and drug habits.

New York Mayor Edward Koch, in an interview, proposed that syringes and needles be made available to drug users in an attempt to curb the spread of AIDS. The proposal was found unacceptable and ineffective since drug users prefer to pass the needle around. Condoms are not 100 percent effective but they can substantially reduce the risk of transmission but are reported to be unacceptable to the sexually promiscuous because they reduce the pleasure of the sexual act.

I find fault with the conclusion that since these high-risk groups of people refuse to take steps to protect their own lives, those of us who are non-drug users and maintain monogamous relationships must be subjected to the risk and complications of AIDS inoculation.

I applaud all the court decisions protecting the constitutional rights of individuals; however, when one must choose between the constitutional rights of the majority and the constitutional rights of the few, how can one support a ruling for the latter, particularly in a democracy which, by definition, is ruled by the majority?

(signed) Frank Gingerelli, M.D.

Testing for AIDS

November 17, 1987

Dear Doctor Krosnick:

As the oldest medical society, MSNJ has an opportunity to lead the way to unpoliticize acquired immunodeficiency syndrome (AIDS) and treat it not as a civil rights problem but as a public health problem!

Some researchers have found for those who have AIDS and remain healthy after five years, the infection increases dramatically and the patients eventually die or eventually suffer AIDS-related dementia as reported at San Francisco Hospital.

In the United States, people at high risk of AIDS include heroin addicts, homosexual men, bisexual men, organ transplant recipients, blood recipients, prostitutes, sexually active heterosexuals including those who practice vagina-anal intercourse, and the sexual partners of all of the above. The last three groups may innocently or unknowingly spread the virus.

The cure or a vaccine may be at least a decade off since the virus mutates easily; meanwhile the toll is reaching epidemic proportions.

The economic effects will be staggering as the number of AIDS patients increases (average cost at least \$60,000 to \$100,000), with a loss of productive years since AIDS strikes people in the 20 to 40 age group; there will be increases in the costs of treating related complications such as ARC, tuberculosis, and dementia, in the costs of testing and educating the public, in research and development of treatments or a vaccine, and in waste in federal government in fighting the epidemic or possibly quarantining millions of carriers. In addition, there will be legal cost of suits and countersuits.

To add to our medical-legal nightmare, a current decision in North Carolina found AIDS to be a handicap (failure to comply with Section 504 of the Rehabilitation Act which prohibits discrimination by health providing facilities because of a handicap). The U.S. Supreme Court upheld this decision as well as one that tuberculosis is a handicap. This will lead to many more suits and countersuits which already have started.

Employers in many health facilities find themselves in a quandary as they may find themselves liable for a discrimination suit based on

handicap and need to have a responsibility to other employees and patients who, out of fear, will avoid these facilities which hospitals can ill afford.

We saw and heard at our Annual Meeting some of us who are opposed to mass testing, maintaining that there is no point in finding the victims of AIDS because there is no cure and there are false positives or negatives. This is a callous approach to a life-and-death situation!

Mass screening has been condemned by civil liberties' and gay rights' activists, and even the AMA; however, the issue of the health of society or civilization as a whole must be preserved no matter what the price. The social stigma should be less now that heterosexual males and females (as well as babies) are involved. Also, keep in mind how

this disease affects the nation's blood supply and organ donations.

The Centers for Disease Control is considering a recommendation that AIDS antibody testing be administered to all routine hospital admissions and marriage licenses. At present, this test is required for blood donors, military recruits, and state department and foreign service offices. To this, we must add prenatal tests. If the incidence of AIDS is found to be high or getting higher, then mass screening (repeated at certain intervals) should be done.

Preventative measures at present seem to be "information" about AIDS—using condoms and voluntary testing. How are we actually to know who and how many have this dread disease? Must we wait until they come down with the symptoms before the diagnosis is made? How

about the innocent contacts that might have been made?

We are dealing with a fatal communicable disease for which there is no vaccine or cure, and none in the foreseeable future. We must stop the spread! The cost of saving lives, no matter how great, is worth the inconvenience and price. Confidentiality is important but like syphilis, contacts must be traced. We have mandatory tests for rarer diseases; isn't it justified for one that potentially affects millions and is fatal?

MSNJ can be a leader by strongly recommending these tests be required. We have everything to lose in not protecting society from this scourge. Privacy and confidentiality should be protected but should not interfere with the protection to prevent control of this disease.

(signed) A.D. Kovacs, M.D.

Current Surgery of the Heart; Pediatric Intensive Care; The Physician as Teacher; Functional Anatomy in Sports

Current Surgery of the Heart

Arthur J. Roberts, M.D., and C. Richard Conti, M.D., (eds). Philadelphia, PA, J.B. Lippincott Company, 1987. Pp. 343.

"The purpose of *Current Surgery of the Heart* is to identify and describe selected major advances related to the surgical treatment of heart disease." So state the editors, and to this end, they proceed with the assistance of 42 cardiologists, cardiac surgeons, and representatives of related specialties.

Laser coronary recanalization and cardiac fiberoptic endoscopy are reviewed although the latter still requires definition for its application and advantage over existing diagnostic methods. Experience with intraoperative balloon catheter dilation is documented. Mechanical assist devices for support of both left and right heart circulation are updated with the newer generation technology and biocompatibilities. The mechanical heart substitute, with its "bridge" capabilities for

cardiac transplantation, remains fraught with major morbidity and mortality. The need for accelerated investigative and fundamental research is emphasized. Cardiac transplant history and current state of the art are exceptionally well addressed and focus on patient selection, perioperative care, and newer immunosuppressive agents, specifically cyclosporine. Experience with heart-lung transplantation in selective patients is touched upon. Early primary corrective repair of congenital heart defects now is coming of age with favorable reports on long-term survivals and improved functional capabilities. Sophisticated analysis of electrophysiologic phenomena and their clinical counterparts with mapping techniques has allowed removal of predetermined arrhythmogenic foci for the treatment of atrial supraventricular and ventricular arrhythmias. Similarly, somatosensory-evoked potentials during thoracic aneurysm surgery have been determined to avert catastrophic paraplegia. Newer elaborate but smaller cardiac pacing systems are described in great detail. All therapeutic modalities for myocardial revascularization are discussed with indications of their relative efficacies. Myocardial protection, including historical development, mechanism of injury, hypothermia, cardioplegia, and reperfusion injury is a chapter to be highlighted for its completeness yet simplistic presentation.

These are but a few comments on the contents of this book, whose 24 chapters also include mitral valvuloplasty, newer valve prosthetics, and early myocardial revascularization in the evolving myocardial infarct. Computerized perfusion technology and cardiac anesthesia techniques, so vital to successful surgical outcome, are thoroughly discussed which helps facilitate the editors' emphasis on selected major advances that contributed to current state of the art. The editors are to be congratulated in selecting participants whose writings are clear, concise, complete, and nonrepetitive.

Current Surgery of the Heart is deserving of its title and should be read by all medicos who seek familiarity with the status of cardiac surgery, and its chartered and unchartered future.

Joseph Alpert, M.D.

Pediatric Intensive Care

Jeffrey P. Morray, M.D., (ed). Norwalk, CT, Appleton & Lange, 1987. Pp. 581.

For this volume, concise and useful pathophysiologic summaries are combined with classically organized comments on diagnosis and management, all arranged in a traditional anatomic-physiologic disease-oriented structure. This multi-authored text displays a regional orientation but the editor's introduction is careful to disclaim any attempt to provide a magisterial approach or a survey of diverse opinions. The contents, arranged by systems, deal with fluids, cardiovascular, central nervous system, pulmonary, hematologic, renal, gastrointestinal, endocrinologic, and infectious disease. Other divisions are concerned with ethical issues, trauma, pharmacology, and transport. The standard of expository prose is good. Medical clichés and jargon are not intrusive. Both sustained perusal of a section or dipping for particular points were comfortable to do.

Three general negative comments are worth stating. First, there is inconsistency among the chapters in the extent to which emergency care, as compared to intensive care, is described; one often wishes for a bit more of the former. Second, there is inconsistency in the extent to which the pragmatic specifics and therapies are described. Third, there was little enough said about the "care" in intensive care, and very little indeed about parents and families. One particular point: I could not find reference to tibial marrow infusion of fluids.

This book may be recommended to provide the young doctor with a reference for all the topics which it contains, and for the older doctor as a standard against which to compare his own thoughts and actions.

Avrum L. Katcher, M.D.

The Physician as Teacher

Thomas L. Schwenk, M.D., and Neal A. Whitman, Ed.D. Baltimore, MD, Williams & Wilkins, 1987. Pp. 203. (\$21.50)

How many of us recall, as students ourselves, the pedantic bores who lectured and put us asleep with

their monotonous slide presentations or speeches requiring little or no interchange or questioning in the darkened lecture hall? Remember the professors who came late to the meeting rooms with pompous excuses for their tardiness?

The Physician as Teacher is highly recommended for those involved with student groups. The preface of this small paperback says it all: physicians by definition are teachers; their knowledge and skills are needed by all medical students, nurses, and other health professionals and by civic groups in community, political or religious settings.

The purpose of this book is to help the physician become a better teacher by organizing his or her thoughts and methods of teaching.

Part One suggests the teaching

plan: methods of communication, discussion groups, feedback, evaluation and enhancement of understanding, and retention of facts and stimuli towards continued self study. At the conclusion of this part, the authors provide good examples for all of the different plans presented.

Part Two presents practical guidelines in setting up the didactic and clinical teaching exercises. Again, examples are given for lectures to small or large groups; discussion plans, teaching rounds in bedside or ambulatory settings. Hints on self improvement and creative methods of teaching complete the subject. An abundant bibliography is included at the end.

Do not face your next student group without first reading this fine text. Harry M. Poppick, M.D.

Functional Anatomy in Sports

Jurgen Weuneck, M.D. Chicago, IL, Year Book Medical Publishers, Inc., 1986. Pp. 220.

This book is aimed primarily at the athletic trainer and other nonmedical personnel and is essentially a basic anatomy text with emphasis on movement and the anatomical structures involved.

The latter chapters of the book relate various muscles to specific sports and how they function. The final chapter is devoted to muscle strength training and exercises.

The book is of only marginal interest to physicians, but is a good practical text for the athletic trainer and coach, and would be worth purchase by them.

Christine E. Haycock, M.D.

***Drs. Aronoff; Del Deo;
Geller; Glass; Graziano;
Kane; Krakower; Love;
McMahon; O'Rourke;
Pedowitz; Pierce;
Saracino; Stevenson***

Dr. Solomon Aronoff

Retired Jersey City allergist Solomon Aronoff, M.D., died on October 10, 1987, at the age of 73. Dr. Aronoff received his medical degree from the Faculty of Medicine, University of Edinburgh, Scotland, in 1938. He began practice in Jersey City after serving as a captain in the United States Army medical corps during World War II. He maintained this practice for over 25 years. Dr. Aronoff served as head of the allergy departments at Jersey City Medical Center, St. Francis Community Health Center, both in Jersey City, and St. Mary Hospital in Hoboken. A Diplomate of the American Board of Immunology and Allergy, Dr. Aronoff was a Fellow of the American Academy of Allergy, the American College of Allergy, the New Jersey Allergy Society, the American Association for Clinical Immunology and Allergy, and the New York Academy of Sciences. In 1984, the American College of Allergists honored him as one of four outstanding allergists in America. Dr. Aronoff was a member of our Hudson County component.

Dr. Nicholas V. Del Deo

Retired in Spring Lake Heights after many years of pediatric practice in Newark, Nicholas V. Del Deo,

M.D., died on September 22, 1987, at the age of 93. A native of Newark, Dr. Del Deo received his medical degree from Bellevue Hospital Medical College, New York, in 1918. He was affiliated with Columbus Hospital, St. Michael's Medical Center, and UMDNJ-University Hospital, all in Newark. From 1918 to 1920, he served as lieutenant in the United States Navy. Dr. Del Deo was a member of our Essex County component and of the American Medical Association. For his 50 years as a physician, Dr. Del Deo received the Medical Society of New Jersey's Golden Merit Award in 1968.

Dr. Samuel Geller

Retired specialist in internal medicine and allergy, Samuel Geller, M.D., died on October 18, 1986, at the age of 80. Born in Russia, Dr. Geller emigrated to the United States, and attended the University of Maryland School of Medicine, Baltimore, receiving his medical degree in 1932. He was a physician in the allergy clinic at United Hospitals Medical Center, Newark, while maintaining a private practice. Dr. Geller was an Associate Fellow of the American College of Allergists, and a member of our Essex County component and of the American Medical Association, as well as the New Jersey Allergy Society. For his 50 years of medical practice, Dr. Geller received the Medical Society of New Jersey Golden Merit Award in 1982.

Dr. Arthur M. Glass

After 45 years of maintaining a family practice in Camden, Arthur M. Glass, M.D., died on September 23, 1987, at the age of 74. Dr. Glass attended Hahnemann Medical College in his native Philadelphia, where he received his medical degree in 1949. He was a member of our Camden County component and of the American Medical Association.

Dr. Alexander J. Graziano

Retired pediatrician Alexander John Graziano, M.D., of Madison, died on September 20, 1987, at the age of 56. A native of Hoboken, Dr. Graziano received his medical degree from Georgetown University School of Medicine, Washington, D.C., in 1956. While maintaining a private practice in Cliffside Park for

many years, Dr. Graziano served on the staff of St. Mary Hospital, Hoboken. Before retiring in 1972, he was a physician with CIBA Pharmaceutical Company, Summit, for six years. Dr. Graziano served in the United States Army as captain from 1959 to 1961. He was a member of our Bergen County component and of the AMA.

Dr. Sydney H. Kane

Sydney H. Kane, M.D., a retired specialist in pediatrics and biostatistics, died on September 7, 1987, at the age of 70. Born in Philadelphia, Dr. Kane received his medical degree from Temple University School of Medicine, Philadelphia, in 1940. He maintained a private pediatric practice in Philadelphia from 1944 to 1968. As a consultant in pediatrics, Dr. Kane was affiliated with Frankford Hospital and Northeastern Hospital, both in Philadelphia. Dr. Kane was a research instructor in pediatrics for the Women's Medical College, Philadelphia. From 1968 until his retirement, he was manager of biostatistics system analysis for CIBA Pharmaceutical Company, Summit. Dr. Kane was a Fellow of the American Heart Association; he was a member of our Union County component and of the American Medical Association. During World War II, he attained the rank of first lieutenant in the United States Army.

Dr. Alvin H. Krakower

After years as a gynecologist in Paterson and Fair Lawn, Alvin Harold Krakower, M.D., died on September 30, 1987, at the age of 70. Born in Paterson, Dr. Krakower received his medical degree from the University of Arkansas School of Medicine, Little Rock, in 1941, specializing in gynecology and nutrition. He became affiliated with Barnert Memorial Hospital Center, Paterson, and was elected president of its clinical society in 1962. Dr. Krakower was a founding Fellow of the American College of Obstetricians and Gynecologists; he was a member of our Passaic County component, and of the American Medical Association. A veteran of World War II, Dr. Krakower served as a captain in the United States Army Air Force medical corps, before beginning private practice in 1947.

Dr. Elizabeth F. Love

Former hospital administrator Elizabeth Ford Love, M.D., retired in Medford, died on August 17, 1987, at the age of 94. Born in Moorestown, Dr. Love received her medical degree from the University of Pennsylvania School of Medicine, Philadelphia, in 1919. She became affiliated with Memorial Hospital of Burlington County, Mt. Holly, and was an administrator at Jeanes Hospital, Philadelphia, from 1941 to 1953. Active in the community, Dr. Love was a lecturer in social hygiene for the New Jersey Department of Health, and was school physician for the townships of Moorestown, Maple Shade, and Mt. Laurel. She was a member of the American College of Hospital Administrators, of our Burlington County component, and of the American Medical Association. In 1969, Dr. Love received the Medical Society of New Jersey's Golden Merit Award.

Dr. Edward F. McMahon

Retired since 1984 from his Newark psychiatry practice, Edward Frank McMahon, M.D., died on August 22, 1987, at the age of 70. Dr. McMahon was graduated from New York University Medical College, New York, in 1957. He was a consultant at Somerset Medical Center, Somerville, from 1973 until his retirement. Dr. McMahon was a member of our Essex County component, the American Psychiatric Association, and the Academy of Psychosomatic Medicine.

Dr. John P. O'Rourke

Retired since 1979, from 31 years of general practice in Lyndhurst,

John Philip O'Rourke, M.D., died on August 17, 1987, at the age of 61. A native of Lyndhurst, Dr. O'Rourke was graduated from New York University School of Medicine in 1954. He was affiliated with the General Hospital Center at Passaic, where he served as vice-chairman of the board of governors, member of the executive committee, and president of its staff. He was a member of our Passaic County component. Dr. O'Rourke served as a sergeant in the Army.

Dr. Paul Pedowitz

A specialist in obstetrics and gynecology, Paul Pedowitz, M.D., died on May 11, 1987, at the age of 70. Born in New York, Dr. Pedowitz received his medical degree from Long Island College of Medicine, Brooklyn, in 1941. He became affiliated with Newark Beth Israel Medical Center and UMDNJ-University Hospital, both in Newark, and Elizabeth General Medical Center. Dr. Pedowitz was a professor of obstetrics and gynecology at UMDNJ-New Jersey Medical School, Newark. He was a Diplomate in obstetrics and gynecology, and a Fellow of the American College of Surgeons and the American College of Obstetricians and Gynecologists. Dr. Pedowitz was a member of our Essex County component.

Dr. Michael A. Pierce

Neurosurgery specialist Michael A. Pierce, M.D., died at the age of 68 in March 1987. Dr. Pierce received his medical degree from Albany Medical College, New York, in 1944. He became affiliated with St. Mary's Hospital, Passaic, The Mountainside Hospital, Montclair, Columbus Hospital, Newark, St. Mary Hospital, Or-

ange, and Clara Maass Medical Center, Belleville. From 1945 to 1947, he served with the United States Army medical corps, emerging with the rank of first lieutenant. A Diplomate in neurological surgery, Dr. Pierce was a member of the Essex County component, and of the AMA.

Dr. Franklyn J. Saracino

Retired surgeon Franklyn John Saracino, M.D., of Sarasota, Florida, died on June 30, 1987, at the age of 77. Born in Newark, Dr. Saracino attended the Faculty of Medicine at the University of Rome, Italy, where he received his medical degree in 1937. From 1939 until his retirement eight years ago, Dr. Saracino was a physician and abdominal surgeon at West Hudson Hospital, Kearny. He also served there as secretary of the medical staff. Dr. Saracino was a Fellow of the American College of Abdominal Surgeons, and was a member of our Essex County component and of the American Medical Association.

Dr. Stuart S. Stevenson

Stuart Shelton Stevenson, M.D., one of the founders of Seton Hall College of Medicine, the predecessor of the present University of Medicine and Dentistry of New Jersey, died on July 28, 1987, at the age of 72. A specialist in pediatrics, Dr. Stevenson received his medical degree in 1939 from Yale University School of Medicine, Connecticut. He was the first professor and chairman of the Department of Pediatrics at Seton Hall College of Medicine, and was affiliated with Hague Medical Center, Jersey City. Dr. Stevenson was a Diplomate in pediatrics, and a member of our Hudson County component and of the AMA.

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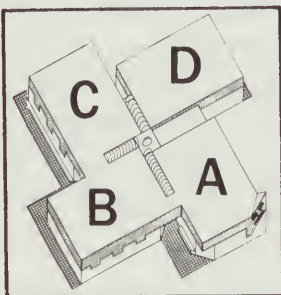


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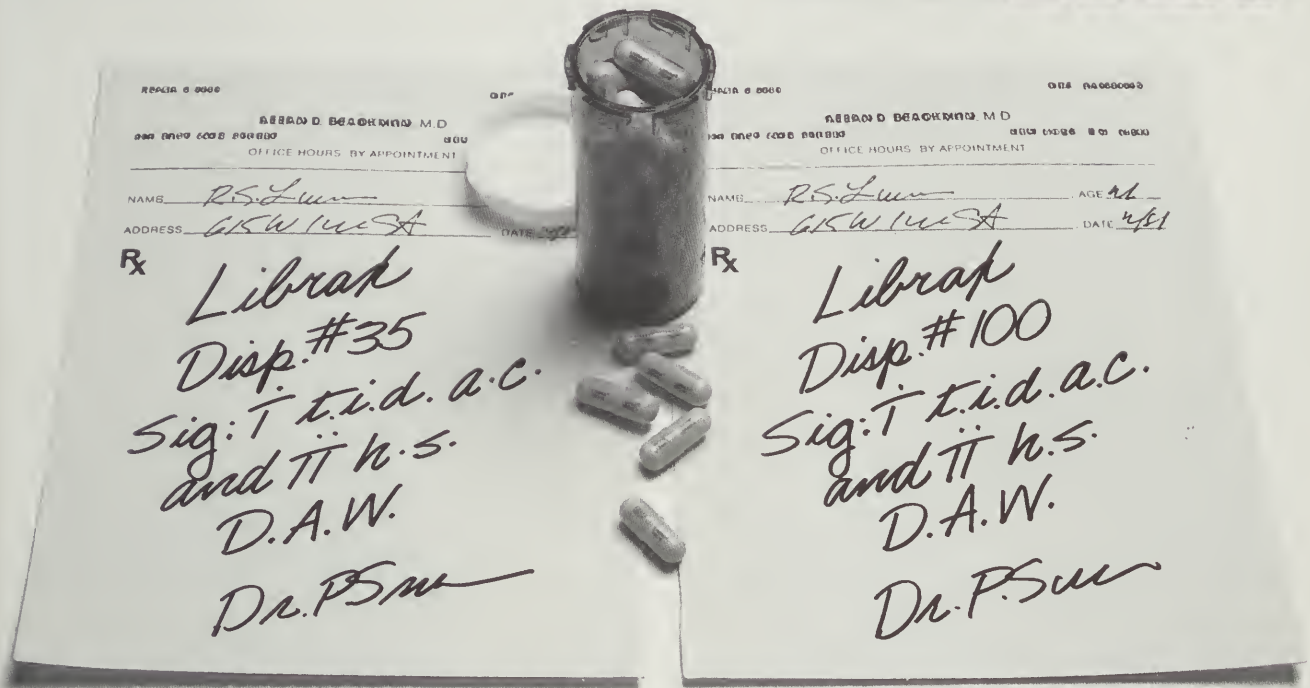
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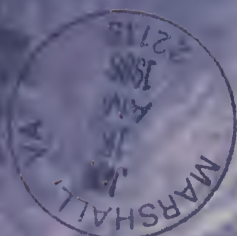
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Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlorthalidone, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. b.i.d. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.),

demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

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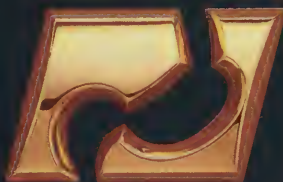
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NEW JERSEY MEDICINE

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

FEBRUARY 1988

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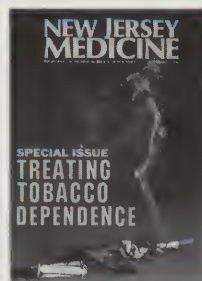
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On The Cover: The tobacco epidemic is an especially difficult medical problem. This special issue on treating tobacco dependence is a first step toward solving the problem. Our coverage begins on page 95.



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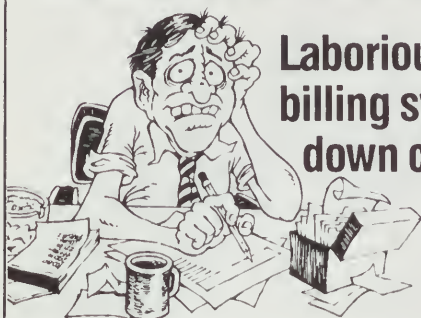
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Contraindications: Known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) reported after abrupt cessation of extended use of excessive doses are similar to those seen with barbiturates. Milder symptoms reported infrequently when continuous therapy is abruptly ended. Avoid abrupt discontinuation; gradually taper dosage.

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ototoxic or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and ocular roge) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Due to isolated reports of exocorbation, use with caution in patients with porphyria.

Adverse Reactions: Drowsiness, ototoxic and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extropyromidal symptoms, increased and decreased libido, all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. **Oral—Adults:** Mild and moderate anxiety disorders and symptoms, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. **Geriatric patients:** 5 mg b.i.d. to q.i.d. (See Precautions.)

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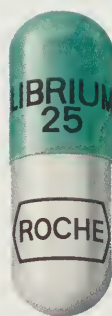
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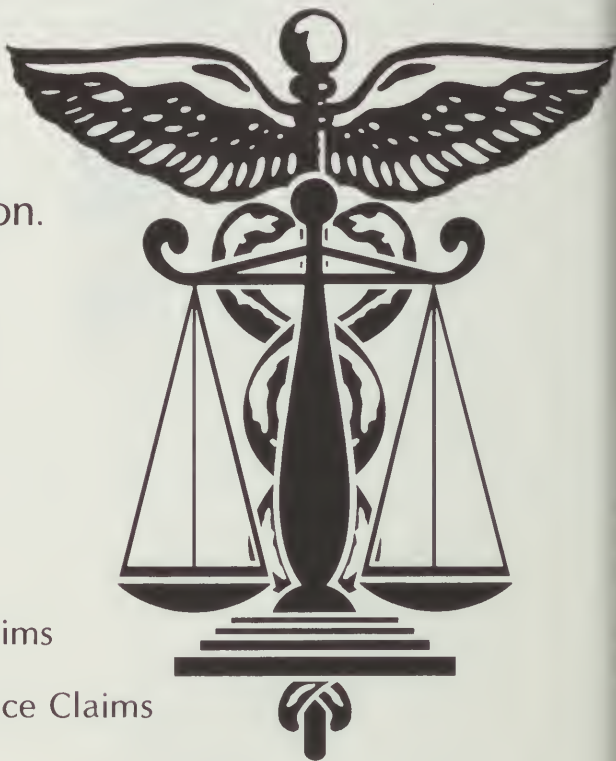
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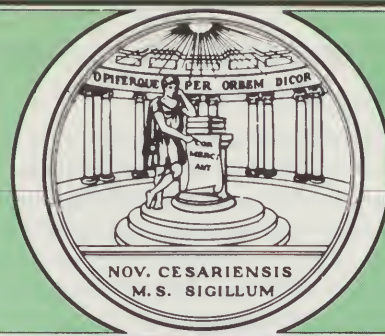
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MEMBERSHIP NEWSLETTER



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THE MEDICAL SOCIETY OF NEW JERSEY

VOLUME 51

AIDS POLICY

A licensee of the Board of Medical Examiners may not categorically refuse to treat a patient who has AIDS or AIDS-related complex, or an HIV positive blood test, when he or she possesses the skill and experience to treat the condition presented. Our licensees have long adhered to a tradition of care. The Centers for Disease Control guidelines, however, do recognize that health care workers with certain physical conditions which render them unduly susceptible to the virus should refrain from direct patient care. The Board will consider each case on an individual basis giving due consideration to any such extenuating circumstances. Of course, even where such extenuating circumstances may exist, the Board would hold that the licensee retains the responsibility to make alternative arrangements for the proper care of a patient. The Board is heartened that no complaint yet has been brought before it regarding such a refusal and we remain confident that our licensees are appropriately shouldering their responsibilities.

CAN YOU HELP?

Project USA, an AMA program to recruit fully licensed physicians for short-term, general medicine assignments at Indian Health Service and National Health Service Corps hospitals and clinics, have vacancies. Vacancies are from two to four weeks and occur in a variety of interesting locations. Participating physicians receive a stipend of \$750 a week plus round trip transportation and living accommodations. Interested physicians should contact John Naughton, AMA, 535 North Dearborn, Chicago, Illinois 60610.

PROPOSED MEDICARE CHANGES

1. **Rollback in physician payments.** Under the Senate Finance Committee package inspired and controlled by Office of Management and Budget (OMB) numbers, physician payments would be rolled back. There would be no update. This would be accomplished by leaving in place the already imposed 2.3 percent sequester cut. The only exception would be for primary care services, although it is not assured. Primary care services could be allowed the 3.6 percent MEI update on April 1, 1988. This update would be made from the current sequestration level; hence, the

final but postponed update for primary care services only would be 1.3 percent. In either case, no catch-up would be permitted.

2. **Lab fees to be slashed.** The Senate Finance package also provides for hefty cuts in the fee schedule for physician office and outpatient lab payments. The proposal under consideration would 1) cut payments 10 percentage points from 62 to 52 percent of prevailing charges with 2) the already scheduled CAP reduction from 115 to 110 percent of actual charges and 3) no 1.4 percent scheduled increase. It is estimated that approximately half of these cuts would be borne directly by physicians.

3. **Physician DRGs.** Proposals have been considered this year that would require inpatient radiology, anesthesiology, and pathology (RAP) services to be paid under the DRG system. We must point out again that physician DRGs would end up doing a great disservice for both doctors and their patients. We are indeed grateful that neither the House nor Senate bills provide for physician DRGs. The provision of the House Energy and Commerce Committee to prohibit the Secretary from implementing any system or demonstration for payment of RAPs through a DRG system recognizes specifically the adverse nature of such incentives (to reduce the amount of care provided to our elderly) in a medical care environment. That Committee's prohibition in the House bill should be maintained.

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GOVERNMENTAL AFFAIRS UPDATE

by CLARK MARTIN

Answering the SCI Report. A better system for the Board of Medical Examiners to handle complaints while protecting the confidentiality of both the accused and the accuser is the Society's main response to the State Commission of Investigation's report on Impaired and Incompetent Physicians.

Released last November, the report made front-page headlines and prime time television news with its charge that a "small percentage of physicians who are impaired constitutes a potentially lethal minority," and that the Board of Medical Examiners neither has the information nor the staffing it needs to act effectively.

The SCI also criticized hospitals and health care professionals for engaging in a "conspiracy of silence" for not reporting physicians who are incompetent or impaired by alcohol, drug abuse, or some mental or physical disability.

To meet the challenges of the report, the Society retained as special counsel Herbert J. Stern, who won national recognition as United States District Court Judge and as United States Attorney for New Jersey. With him, we've met with the SCI to discuss reconsideration of some of its recommendations, testified at a public hearing before the Senate Committee on Institutions, Health and Welfare, and now are submitting our proposals to key legislators.

Our recommendations include:

- Reorganizing the State Board of Medical Examiners (SBME) to separate its adjudicatory and prosecutorial functions. Hence, the Board's legal counsel no longer would serve both as prosecutor and adviser to the Board on guilt, innocence, and penalties.

- Restructuring the SBME's disciplinary system into regional panels which initially would assess whether further action is warranted. Proceedings would be kept confidential and adverse decisions would be made public only after SBME final action. This is modeled after New Jersey's nationally acclaimed system for disciplining attorneys.

- Prohibiting the use in civil suits such as malpractice actions of any information given to the SBME, or any action taken by the Board. In other words, civil plaintiffs must develop their own facts. Attorneys today are given similar protection.

- Establishing a more detailed agreement between the SBME and MSNJ's Impaired Physicians Program to assure that the Board can assess the progress of enrollees while safeguarding confidentiality.

- Guaranteeing immunity from civil liability for those who report suspected impairment or incompetence.

Making Medicaid a Priority. "Human Services Commissioner Drew Altman called today for New Jersey to stop the further decline of the number of physicians and other medical professionals who care for Medicaid patients by increasing the fees they are paid under the State's Medicaid program." So goes the first sentence of a press release issued when Commissioner Altman

testified before the Assembly Health and Human Resources Committee. The date? November 17, 1986.

Now, some 15 months later, the Medicaid payment for physicians remains essentially the same as 15 years ago. This fact, complicated by reduced compensation for Medicare patients, no compensation for indigent patients, and the tremendous financial impact of AIDS treatment on inner city practitioners has created a crisis situation. As Commissioner Altman testified in 1986, Medicaid's "low rates of reimbursement for medical professionals are driving them away from serving Medicaid patients."

In 1988, to prevent a further loss of physicians serving Medicaid patients, the Society has made the program one of its top governmental affairs priorities. We'll be working with the commissioners of Human Services and Health and with key legislators in an attempt to establish rates which will help the Medicaid program realize its goal of assuring quality health care for the poor, encourage physician participation, and redirect patients to the continuing care of private physicians instead of receiving primary care—each time from a different doctor—in more costly hospital outpatient facilities and emergency rooms.

Senate Defeats Optometric Bill. The Society won a major legislative victory in mid-December when the Senate soundly rejected a bill which would authorize optometrists to diagnose disease and prescribe drugs.

The bill, S-2261 (Lynch, D-New Brunswick), received 13 "yes" and eight "no" votes while 15 senators abstained from voting. To pass, a bill needs 21 affirmative votes.

We've fought S-2261 and its predecessors for a number of years. These bills represent a dangerous concept which, unfortunately, has become law in some states: authorizing nonphysicians to practice medicine. S-2261 is not the only bill of its type in our Legislature. A similar measure permitting nurses to diagnose disease and prescribe drugs also was introduced in last year's Senate. Both the optometric and the nursing measures have been reintroduced in the new Legislature which convened last month.

The current Senate nearly is identical in membership to that which voted down the optometric drug bill. This gives our recent victory considerable relevance in the current session.

New Legislature Takes Office. Top leaders of the 1988-89 Legislature are the same as in the past two years. Democratic Senate President John Russo (D-Toms River) and Republican Assembly Speaker Chuck Hardwick (R-Westfield) were re-elected by their majority parties following the November 3, 1987, election. The Democrats gained 1 Senate seat, bringing their majority to 24-16. Democrats also gained 8 seats in the Assembly where Republicans hold a 42-38 edge.

The Society's political action committees, MedAc and JEMPAC, contributed \$180,000 to incumbents and challengers in the 1987 legislative elections.



GOVERNMENTAL AFFAIRS UPDATE

by CLARK MARTIN

Of the 120 legislators serving in the current session, 113 received organized medicine's support. Thanks to the tireless efforts of JEMPAC/MedAc Chairman William E. Ryan, M.D., our political action has become a significant factor in helping us attain a stronger position in the Legislature. To the many members who contributed to our PACs and who took the time to discuss issues with their legislative candidates, many thanks!

"Verified" Bills No Longer Needed. Physicians no longer have to "verify that their services were necessary and were, in fact, furnished" when they bill insurance companies. The cumbersome requirement was deleted from state insurance laws by A-3434, which took effect immediately when Governor Kean signed it on December 28. Sponsor of the new law, which in effect recognizes the advent of electronic billing, is Assemblyman Ralph Loveys (R-Parsippany).

INSURANCE BAILOUT: WHOSE RESPONSIBILITY?

MSNJ and the Medical Inter-Insurance Exchange will use every remedy available, including court action, to defeat the State Insurance Department's confiscatory plan to bail out its now defunct Medical Malpractice Reinsurance Association. The plan was announced early last month.

The Department wants to levy a 4 percent surcharge for an estimated seven years on the professional liability insurance premiums of every physician, podiatrist, and chiropractor in the state in order to pay off the deactivated plan's \$60 million debt. It estimates that the surcharge would cost a general practitioner \$232 and an obstetrician \$1,259 per year.

The Society believes that the Insurance Department does not have the legal authority to enact the plan. The state-run Medical Malpractice Reinsurance Association operated for five years after its activation in 1977 under a law which required the insurance commissioner to "make a finding that medical malpractice liability insurance is not readily available." The fact is that such insurance was readily available in 1977 and the plan was activated solely to create what then-Commissioner James Sheeran felt would be a more competitive market.

Because the state plan sold insurance for unreasonably low premiums—in effect, it was undercutting the Medical Inter-Insurance Exchange—it now is in debt. It holds \$22 million in reserve and anticipates \$82 million in claims over the next decade.

Now the Department proposes that the thousands of physicians who paid more to purchase coverage from the Exchange or from other carriers be further charged for claims against beneficiaries of the State's "bargain."

The Society believes that the deficit should be met either from the state budget or from a surcharge on the 3,300 physicians and 450 podiatrists who purchased the underpriced insurance from the state plan.

PROPOSED RULE MAKING: FAMILY PLANNING CODES

The Division of Medical Assistance and Health Services has submitted a proposal to the *New Jersey Register* which is designed to increase fees for family planning services rendered by independent clinics. The procedure codes affected by the proposed increase include initial visit, followup visit, and revisit. The full text of the rule will appear in a future issue of the *New Jersey Register*.

HEALTHSTART

The Department of Human Services, and the Division of Medical Assistance and Health Services has submitted a proposal which appeared in the November 2, 1987, issue of the *New Jersey Register* at 19 N.J.R. 1978(a). The proposal was submitted in cooperation with the New Jersey Department of Health. The proposal is designed to implement a program of comprehensive maternal and child health care for all pregnant women and dependent children under two years of age in New Jersey who are eligible for Medicaid benefits. This program shall be known as HealthStart. The proposal explains who could qualify as a HealthStart provider, the service package, and the reimbursement schedule. The full text of the proposal has been printed in the *Register*.

BEWARE

A member of the Medical Society of New Jersey has filed a consumer fraud complaint regarding a linen service company that has been soliciting MSNJ physicians. Apparently, the company promises more than they deliver. It is suggested that any physician being offered a free, one-month trial service introductory offer of office linens needs to thoroughly examine the proposal before committing himself.

PREMIUM RATE RENEWALS

Each year it is necessary to adjust the premium rates for the MSNJ insurance programs to reflect expected claim payments, reserves, and administrative expenses for the coming year. The enclosed premium notice includes premium adjustments effective January 1, 1988, as summarized below:

Blue Cross/Blue Shield. The recent claims experience of participants under age 65 has been extremely high. As a result, the Blue Cross/Blue Shield requested an average rate increase of 33 percent effective January 1, 1988. After lengthy negotiations, and by using surplus funds from the 1986 coverage year, the Committee was able to lower the average increase to 25.34 percent. Because the actual increase varies by program and type of contract, participants' individual rate increase may be more or less than 25.34 percent.

Premium rates for persons age 65 and over no longer are set by the New Jersey Insurance Commissioner. Projected costs for all participants now are determined from the combined claims experience of those under age 65 and those age 65 and over. Separate premium rates then were established for each age group according to actuarial studies derived from the Blues' own claims records. These studies found that past premium rates for persons age 65 and over were much too low to cover actual claim costs. The new method of determining premium rates for this age group has resulted in a significant rate increase effective January 1, 1988.

Major Medical. The most recent claims experience of participants in the MSNJ Major Medical program continues to exceed paid premiums.

Due to the spiralling claim costs, premium rates must be increased by an average of 34 percent effective January 1, 1988. This large rate hike is needed to cover the program's anticipated claims over the next year.

Dental. The claims experience under the MSNJ dental program was much lower than expected for the nine-month period ended December 31, 1986. As a result, a refund of almost 25 percent of premiums will be returned to participants in approximately 90 days.

Despite the favorable claims experience during the 1986 coverage year, program costs in 1988 are projected to rise and a 9 percent premium increase took effect January 1, 1988. This increase follows last year's 12 percent decrease so that participants' cost for dental insurance still is lower than it was in 1986.

Comments. The Committee recognizes that this year's Blue Cross/Blue Shield and Major Medical increases are substantial. The increases do, however, reflect the overall utilization of benefits by participating members.

Despite the apparent need for justifiable rate increases, the Committee is pursuing alternatives to the current programs. In the coming months, the Committee will review health care insurance programs available through commercial insurers that may be interested in underwriting the MSNJ group. Other options that will be investigated include self-insurance, alternative funding arrangements, and various cost containment initiatives.

Participants will be kept advised of all future developments concerning the MSNJ Health Care Insurance programs. If you have any questions on your new premium rates, please contact Donald F. Smith & Associates' Insurance Administration Department at 609/924-8700.

UNDERWRITING CHANGES

In conjunction with the 1988 premium rate renewal, the Blues have implemented a number of underwriting changes in the MSNJ Blue Cross/Blue Shield and Major Medical programs. The changes affect current participants as well as individuals considering participation. If you currently are enrolled in the MSNJ program or intend to enroll in the future, please read the following information carefully:

The underwriting changes include:

1. As of April 1, 1988, the Blue Shield Series 500, 750, and 14/20 fixed-fee payment schedules no longer will be offered to new participants or as an upgrade

to current participants. Although a final decision has not been made yet by the Blues, it is expected that these fixed-fee plans will be eliminated entirely by January 1, 1990. At that time, all participants would be enrolled under the Blue Shield P.A.C.E. program.

2. On January 1, 1988, Blue Cross/Blue Shield eliminated the Husband and Wife contract class. Participants who now are covered under Husband and Wife contracts will be enrolled for Family coverage. A new premium rate for Family contracts was developed by combining the claims data of both classes. The change produces a slightly higher rate than a Husband and Wife contract calculated under the old method and a slightly lower rate for a Family contract.

3. As of April 1, 1988, individual participants must be enrolled for the same contract class (i.e. Single or Family) for both Blue Cross/Blue Shield and Major Medical. For instance, participants no longer may enroll for Single coverage under Blue Cross/Blue Shield and Family under Major Medical. It must be one contract class for both coverages. Individuals with Parent and Child(ren) Blue Cross/Blue Shield coverage must be enrolled for Family Major Medical coverage.

4. Beginning April 1, 1988, new participants will be offered Blue Cross/Blue Shield and Major Medical as a single, packaged plan. The coverages will not be available separately. Participants who now have Blue Cross/Blue Shield coverage only can maintain that coverage by itself. Persons age 65 and over will not be eligible to enroll.

Currently, individuals age 65 and over are permitted to enroll in the MSNJ Blue Cross/Blue Shield program only. As of April 1, 1988, this no longer will be permitted. If you are in this age category and intend to enroll in the Blue Cross/Blue Shield program, you must do so prior to April 1, 1988.

Also effective April 1, 1988, participants with Blue Cross/Blue Shield and Major Medical must maintain both coverages to participate. It no longer will be permitted to terminate participation in the Major Medical program and retain the Blue Cross/Blue Shield plan only.

5. On April 1, 1988, minimum participation requirements will be applied to all participating employer units. This means a certain percentage of eligible persons must participate in order for coverage to be made available. If the employer unit cannot achieve the minimum participation level, coverage would not be extended to that particular employer unit.

For current participants, MSNJ Insurance Program records will be reviewed for compliance with the consistent enrollment and minimum participation requirements. Members that do not comply will be contacted by Donald F. Smith & Associates to discuss compliance alternatives.

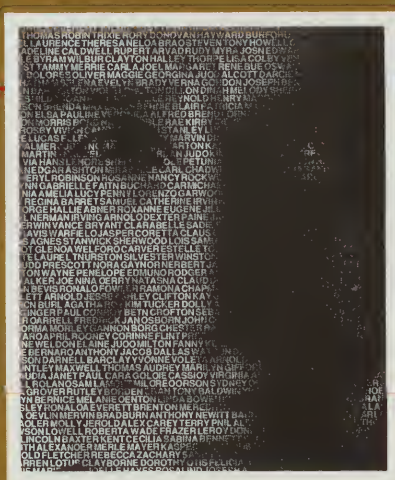
If you have any questions on the MSNJ health insurance programs or the new underwriting changes being implemented, please contact Donald F. Smith & Associates' Administration Department at 609/924-8700.

FINI

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...like the more than one million patients who have received **INDERAL® LA**.

In a recent survey, 4,120 participating physicians gave us their views¹ on **INDERAL LA** in the treatment of hypertension, angina and migraine.

INDERAL LA is their preferred beta blocker

...of the nearly three out of four physicians responding to the questionnaire, an impressive 97% rated **INDERAL LA** good to excellent for overall performance. Virtually all cited efficacy, tolerability, long-term cardiovascular protection and once-daily convenience as important factors in their choosing to prescribe **INDERAL LA**.

INDERAL LA promotes patient compliance

...Virtually every responding physician rated patient satisfaction with **INDERAL LA** to be as good as, or better than, other beta blockers.

Like conventional **INDERAL** Tablets, **INDERAL LA** should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree and bronchial asthma.

ONCE-DAILY
INDERAL LA
 (PROPRANOLOL HCl) LONG ACTING CAPSULES
 60, 80, 120, 160 mg

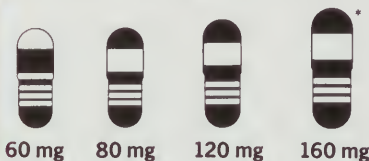
The one you know best keeps looking better

Please see next page for brief summary of prescribing information.

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The one you know best
keeps looking better



60 mg 80 mg 120 mg 160 mg

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL[®] LA brand of propranolol hydrochloride (Long Acting Capsules)

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. **Hypertension:** INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. **CARDIAC FAILURE:** Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3 , and decreasing T_3 .

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be cautioned that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return in increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL (propranolol HCl) is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncope, ataxia or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol. Ethanol slows the rate of absorption of propranolol.

Phenytin, phenobarbital, and rifampin accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and lidocaine have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasisform rashes, dry eyes, male impotence, an Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, sebaceous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSEAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed to full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—Dosage must be individualized. Starting with 80 mg INDERAL LA once daily dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—Dosage must be individualized. The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Reference:

1. Data on file, Ayerst Laboratories.

D7295/188

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Court Decisions

Right To Die Cases; Physician Liable for Another Physician?

NEW JERSEY SUPREME COURT DECIDES THREE RIGHT-TO-DIE CASES

The New Jersey Supreme Court, on June 24, 1987, decided three cases dealing with a patient's right to refuse or terminate treatment. Two of the cases, *In the Matter of Hilda M. Peter* (Docket No. A-78) and *In the Matter of Nancy Ellen Jobes* (Docket No. A-108/109) dealt with incompetent nursing home patients; the other case, *In the Matter of Kathleen Farrell* (Docket No. A-76) dealt with a competent, terminally ill patient being treated at home.

The court in the *Farrell* case concluded that judicial review is not appropriate unless there is some dispute between or among the family members, the treating physicians, and the patient him- or herself. In the case of the competent patient, there is no question that the patient's wishes must control. The caretaker will be protected from civil and criminal liability if it follows the guidelines laid down in the *Farrell* case as follows:

1. A determination must be made that the patient is competent.
2. The patient must be fully informed about his prognosis, the alternatives, and the risk in withdrawal or termination of the treatment in question.
3. The patient's choice must be voluntary and without coercion.
4. The patient's decision must be balanced against the four traditional state interests which could override a decision to terminate treatment. These are the preservation of life; the prevention of suicide; the protection of the integrity of the medical profession; and the protection of interests of innocent third parties. In the *Farrell* case and the other cases discussed below, the court stated repeatedly that it would be difficult to conceive of an instance where the state's interest in the preservation of life would supersede a patient's own desire to terminate life-prolonging medi-

cal treatment. Neither was suicide a question in these cases; it was the illness, not a suicidal intent, which would result in the patient's death. The integrity of the medical profession was not a question here, either. The treating physicians were in agreement with the decision to terminate treatment. The only remaining interest was the protection of innocent third parties. The court found that Mrs. Farrell's two minor sons would be well cared for by their loving father, and were in agreement with the termination of treatment.

5. The decision should be made by the patient and family with the advice of the treating physician. The court in the *Farrell* case was very strong on the involvement of family members in these types of decisions. It is significant to note that if there are close family members, it no longer is necessary in New Jersey to seek appointment of a guardian, even in the case of an incompetent patient.

6. If the patient is being cared for at home, two nonattending physicians should examine the patient to determine competency and the fact that the patient is fully informed of his prognosis, the risks of removal of the treatment, and the alternatives. The court noted as an aside that in a hospital, many people would be looking at the patient and that the prognosis committee often will be convened to confirm the medical diagnosis and prognosis.

As stated, the court in the *Farrell* case made it quite clear that caregivers who implement these procedures will not be subject to civil or criminal liability for the termination of life-prolonging treatment of a competent patient at the patient's request. The procedures to be followed in the case of an incompetent patient are somewhat more complex, and were dealt with in the *Peter* and *Jobes* cases.

Both cases involved nursing home patients, who had been diagnosed as being in a persistent vegetative state; in *Peter's* case, an elderly patient (65); in *Jobes's* case, a younger one (31). In these cases, the court clarified a number of troubling questions which can arise for health care providers.

Hilda Peter, while competent, had executed a power of attorney which specifically authorized a close friend to make all decisions with respect to her health, as if he were next of kin, to consent to medical treatment, and to manage and direct her medical care. Although not a model of clarity, this document did play an important role in the court's ultimate decision.

There came a point in time when Ms. Peter's close friend sought a court adjudication of Ms. Peter's incompetency, and authorization to withdraw medical care. The court declared Ms. Peter incompetent, but ordered that her friend make no decision to withhold or withdraw medical care or treatment without first notifying and obtaining the consent of the New Jersey Ombudsman for the Institutional Elderly. The friend desired to remove the nasogastric tube which was providing sustenance to Ms. Peter. The Ombudsman refused to consent, applying the standards set forth in the 1985 case *In re Conroy*, because medical examinations indicated that Ms. Peter would not die within

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are Director of the Department and Director of Special Projects, respectively.

one year and this was a requirement in *Conroy*.

In this case, the court reaffirmed its statement in *Conroy* that an individual does not lose the right of self-determination when that individual becomes incompetent. However, the court indicated that a persistent vegetative state is substantively different than the terminal condition in which Ms. Conroy found herself, and, therefore, said that the standards applied must, to some extent, be different. Life expectancy of a patient in a persistent vegetative state is not an important criterion.

The court found clear and convincing evidence of Ms. Peter's desire not to be sustained in her present condition. The court also stated that where a close friend had been specifically designated by the patient to make medical decisions, or where there are close family members (and the court defined these as parents, spouse, siblings, or adult children), the appointment of a guardian is not necessary, and the family members or close friends so designated can be the surrogate decision-makers for the incompetent patient. In the nursing home situation, the Ombudsman must still be called in to determine that the elderly patient has left clear and convincing evidence of her desires and that, after securing two independent medical opinions which confirm the patient's medical condition, the medical alternatives, the risks involved, and the likely outcome if medical treatment is discontinued, the Ombudsman should defer to the decisions of the designated decision-maker. If there is no close family member, and no personal friend has been designated, a guardian should be appointed to deal with the Ombudsman on the nursing home's behalf.

Jobes also involved a nursing home patient in a persistent vegetative state, but not one over whom the Ombudsman would have jurisdiction. Mrs. Jobes's condition was caused by an anesthetic misadventure. Her husband and parents requested that a jejunostomy tube be removed. The nursing home refused, and the matter went to court.

There was some disagreement among the experts as to whether Mrs. Jobes was actually in a persistent vegetative state. The Supreme Court deferred to the trial court in determining which experts were more credible. Obviously, this is a problem if, as the court itself recommends, it is attempting to keep these cases out of the adversary judicial process. The bottom line is that if there is any disagreement as to the patient's condition, the matter probably will end up in court.

That having been said, the court made it clear that, where there is no reliable evidence of the patient's desires, deference will be given to close family members' substituted judgments. The court established the following procedures:

1. If there are, in the attending physician's good-faith opinion, close and caring family members who are willing to decide whether or not to refuse life-sustaining medical treatment for an irreversibly vegetative patient, there is no need for a guardian to be appointed.

2. If there are no close family members, and no surrogate decision maker has been designated by the patient (see *Peter* above), then an application must be made to the court for a guardian to be appointed.

3. In a hospital, the patient's condition must be confirmed by a Prognosis Committee; namely that the pa-

tient is in a persistent vegetative state and there is no reasonable possibility that the patient might recover to a cognitive, sapient state.

4. Once such confirmation is received, if the family/guardian and the attending physician concur that life support should be withdrawn (i.e., that the patient would want it withdrawn) it may be done without judicial review. In such circumstances the physician and the hospital will be immune from civil or criminal liability, if they acted in good faith and in accordance with these procedures.

5. In the nonhospital setting where there is no prognosis committee, the confirmation of two independent physicians, knowledgeable in neurology, along with the opinion of the attending physician, will substitute for the prognosis committee.

Finally, the court ruled that, under the circumstances of this case, the nursing home could not refuse to participate in the withdrawal of the j-tube. The main reason for this appears to be that the home gave no notice to the family of their ethical policies, and the refusal would frustrate Mrs. Jobes' right of self-termination. The importance of clearly establishing and notifying patients upon admission of any policies which would interfere with the free exercise of this right should be obvious. Subsequent petition for review by the United States Supreme Court in this case was denied. Mrs. Jobes died shortly thereafter. (Written by William P. Isele, a partner in the East Brunswick law firm, Gross & Novak, P.A., and an adjunct professor of health law at Seton Hall University School of Law.)

JURY TO DECIDE IF THREE PHYSICIANS ARE LIABLE FOR ONE ANOTHER'S MALPRACTICE

A jury should decide whether three physicians held themselves out to the public as a joint venture, so as to make them vicariously liable for one another's malpractice, a New York Appellate court ruled. A 36-year-old patient who had suffered from cerebral palsy since birth underwent an operation to have electrodes implanted in his brain to stimulate the cerebellar cortex. A second operation was performed a year later. After the second operation, hydrocephalus developed. As a result, the patient claimed he was permanently confined to a wheelchair and had lost vision of his left eye. He filed an action against the three physicians who were the senior physicians of the institute where the surgery was performed. Reversing a trial court's decision dismissing the complaint against the two physicians who did not perform the two operations, the appellate court said that it was a jury question as to whether the three physicians held themselves out to the public as a joint venture or physicians practicing jointly. If that were the case, then all three would be liable for the acts of the physician who performed the two operations. The patient served a summons and complaint only on the physician who performed the operations. If the patient were a patient of the entire medical group, then his timely service of a summons and complaint on the operating physician also constituted timely service on the other two physicians. The court said the two physicians should not have been dismissed from the case on their summary judgment motions. (*The Citation*, Vol. 55, No. 8, August 1, 1987)

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Spare your patients the rigors of
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25 mg Hydrochlorothiazide/50 mg Triamterene/SKF

Effective antihypertensive*
therapy...without
the bananas

DAW
'DYAZIDE' AS WRITTEN.

* Not for initial therapy. See brief summary.

Before prescribing, see complete
prescribing information in
SK&F CO. literature or PDR.
The following is a brief summary.

WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or

without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin[ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak lolic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The

following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

BRS-DZ-L45

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INTRODUCTION

On June 1, 1986, the Board of Trustees of the Medical Society of New Jersey banned smoking in its headquarters for all employees, members, guests, and committee functions. The Board took this action due to the "overwhelming evidence against smoking, developing liability laws, state laws relating to the providing of a smoke-free environment in the workplace, and financial considerations." Such a policy was accepted without challenge, and, to this day, the building remains smoke-free.

The purpose of this special issue, "Treating Tobacco Dependence," is to share reflections on this problem with our readership. Developing a smoke-free society is a slow, lengthy process. We believe the information contained in this issue will help us all move toward this goal.

The following poem, written by Robert S. Vena, gets right to the heart and lung of the matter:

*After 40 years of smoking
I found the strength to stop
It started when I was 10 years old,
I stole them from my Pop.*

*I can hardly walk a city block
or blow out a lighted match
My lungs are just as black as coal,
My breath is hard to catch.*

*I thought it made me grown up
Like Bogey and Bacall,
I've shelled out many thousands
on 'Little Johnny's Call.'*

*Hoping that it's not too late
To help the very young
To replace their smoking habit
Before they misplace a lung.*

We would like to thank John Slade, MD, for his contributions to this special issue. Photographic credits are as follows: pages 102, 109, 116-117, 120, 131, 139-140, 143, 152-153, John Slade, MD; page 97, Jim Towns; page 121, Association for Nonsmokers—Minnesota; page 108, Andrew Hahn, MD; page 111, Sarah Schenck; page 119, American Cancer Society; and page 154, Arizonans Concerned About Smoking. Cover photograph by Stan Godlewski.

Additional funds for this project have been provided by the New Jersey Department of Health, the American Heart Association, New Jersey Affiliate, Inc., and the Medical Society of New Jersey.

Geraldine Hutner
Managing Editor

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The Role of Health Professionals

JOHN SLADE, MD

Tobacco has been a source of personal discomfort and embarrassment for many of us. Frequently, we have cared for patients for many years only to lose them to a fatal illness caused by tobacco. At such times, we may recall unheeded advice to quit smoking, and we may even have asked ourselves whether there was anything else we could have done to help our patients stop smoking in time or even to not start in the first place. This profound frustration, in part, has grown out of a mistaken paradigm about tobacco and nicotine dependence. This special issue of *NEW JERSEY MEDICINE*, which entirely concerns tobacco, is an attempt to offer a more productive approach to the treatment and prevention of nicotine dependence than most of us were taught.

Medical training and practice for the last generation has emphasized the important research findings which demonstrated the myriad ways in which nicotine dependence produces morbidity and mortality. Circumspect jargon referring to tobacco as a "risk factor" for disease, however, has interfered with the development of an appreciation for nicotine dependence as a primary disorder which regularly

produces lung cancer, coronary artery disease, and chronic obstructive pulmonary disease as complications.¹ Since 1980, though, the American Psychiatric Association has classified nicotine dependence as a pathological process with remarkable similarities to other chemical dependencies. The current edition of the *Diagnostic and Statistical Manual* extends and amplifies this recognition of the underlying unity among the addictions.²

Medical school curricula have ignored the management of tobacco dependence even more steadfastly than they have failed to teach useful clinical approaches to alcoholism. A popular textbook of internal medicine tells its readers to advise patients who smoke to cut down if they cannot or will not follow advice to quit smoking.³ Such advice, in a chapter on alcoholism, would be quickly expunged because of the collusion involved in the physician sanctioning a chemical dependency. The contemporary definition of an addiction has important implications for management: A chemical dependency is the loss of control over the use of a substance plus continued use despite problems from that use.² Advice to cut down is an invitation to continue using. Any reduced level of consumption usually is not maintained for long, and the risk of harm to self or others is not avoided.

Nicotine dependence is responsible for more deaths than any other cause of preventable death.⁴ The benefits, then, from successful treatment and prevention are enormous. Thomas Kottke, a cardiologist at the University of Minnesota, points out that a 15 percent reduction in the prevalence of smoking prevents more deaths from myocardial infarction (MI) than does caring for acute MIs in coronary care units (CCU). We have not hesitated to pour enormous energy and resources into establishing and maintaining CCUs. The effort to control

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PLACE
STAMP
HERE

Representative _____
United States House of Representatives
Washington, D.C. 20515

Dear Representative:

I wish to inform you that one of your constituents, who was a patient of mine, has died. The death was due to the following disease:

- ☐ lung cancer.
- ☐ other tobacco-related cancer (includes mouth, larynx, esophagus cancer).
- ☐ chronic obstructive lung disease (includes emphysema).
- ☐ coronary heart disease.
- ☐ other tobacco-related vascular disease.

This person was a smoker or a smokeless tobacco user. Tobacco use is the major avoidable cause of this disease.

I urge you to co-sponsor and actively support legislation (such as H.R. 1272) that would prohibit the advertising and promotion of this uniquely harmful product. Please keep this person's tobacco-related death in mind as you consider this issue.

Sincerely,

Signed

Address

The Medical Society of New Jersey is supporting a postcard campaign to promote AMA-sponsored legislation which would ban tobacco product advertising and promotion. This approach, which personalizes mortalities from tobacco use for members of Congress, was first employed by the British Medical Association a few years ago. Supplies of the postcard are available from county medical societies in New Jersey.

nicotine dependence will not likely be so expensive, yet its benefits certainly will be greater. One approach taken by the Medical Society of New Jersey is supporting a postcard campaign to promote AMA-sponsored legislation which would ban tobacco product advertising and promotion (Figure).

THE SPECIAL ISSUE

This special issue grew out of a symposium presented at the Academy of Medicine of New Jersey in April 1987 sponsored by the Medical Society of New Jersey, the New Jersey State Department of Health, and the Academy, and cosponsored by the New Jersey chapters of the American Cancer Society, the American Heart Association, the American Lung Association, and the American Psychological Association. Its purpose was to provide the medical community with information and tools for the management of nicotine dependence. Nearly every member of the faculty from that symposium has contributed to this issue; in addition, this issue contains a timely report from the Health Department's Commission on Smoking or Health.

At the symposium, the Medical Society of New Jersey honored the singular contributions of two individuals to the control of nicotine dependence in New Jersey: Matt Martin was cited for his many years of leadership developing public health policies to control the tobacco disease epidemic in New Jersey, and Geraldine O. Delaney was honored for her accomplishment at Little Hill-Alina Lodge, New Jersey's first smoke-free health care facility.

A PREVIEW OF THE ISSUE

In his article on nicotine dependence, Jack Henningfield from the National Institute on Drug Abuse reviews the scientific basis for our understanding of nicotine dependence as a primary substance use disorder; much of the work in this area was conducted in his laboratory. Tracy Orleans shares a practical approach to the management of this disease based on a thorough understanding of the current research literature as well as on her years of experience as a clinician and researcher in a variety of outpatient and inpatient settings. Geraldine O. Delaney reports on her approach to the treatment of nicotine dependence simultaneously with the treatment of alcoholism at Little Hill-Alina Lodge. She reports that after prohibiting tobacco use there in March 1985, there was no reduction in applications to her program, and there is still a waiting list for admission. Elizabeth Wilson discusses the enormous contribution nursing can make to the treatment and prevention of nicotine dependence. Regina Carlson and Lawrence Meinert explore several aspects of clean air policies in the workplace. Ms. Carlson shares

insights gleaned from years of experience in helping businesses become smoke-free, and Dr. Meinert reviews the scientific evidence of harm from second-hand tobacco smoke. The article on smoke-free hospitals by Jeffrey Burtaine reviews the enormous progress which has been made in these key institutions over the past four years. Bonnie Vierthaler, founder of the Badvertising Institute, writes about her satiric series of collages, "The Joy of Smoking." In addition to the school exhibits for which she created the show, "The Joy of Smoking" has been enthusiastically received at three national medical meetings and was featured at the symposium in Lawrenceville last April. The final contribution to this special issue may be the most important one. The Commission on Smoking or Health, with Dr. Reichman as Chairman, issued a report in November on children and tobacco; the recommendations are a blueprint for preventing nicotine dependence in today's young people. This report has been endorsed by the Board of Trustees of the Medical Society of New Jersey.

CONCLUSION

Nicotine dependence is a huge problem, but it can be a manageable one. Health professionals need not be overwhelmed and made to feel powerless by *Nicotiana tabacum*. As with other complex problems in medicine, this one has many component parts, and each one, by itself, is tractable in its own way. We need to analyze these smaller problems with care and adopt appropriate tools for solving each of them. Finally, we need to recognize and create opportunities to use these tools. In this manner, health professionals have made enormous strides against numerous other diseases. There is great opportunity here: nicotine dependence is both treatable and preventable, and the needed tools are at hand. This special issue will serve its purpose if it stimulates thinking, learning, and action against nicotine dependence, the most prevalent deadly disease the nation faces today. ■

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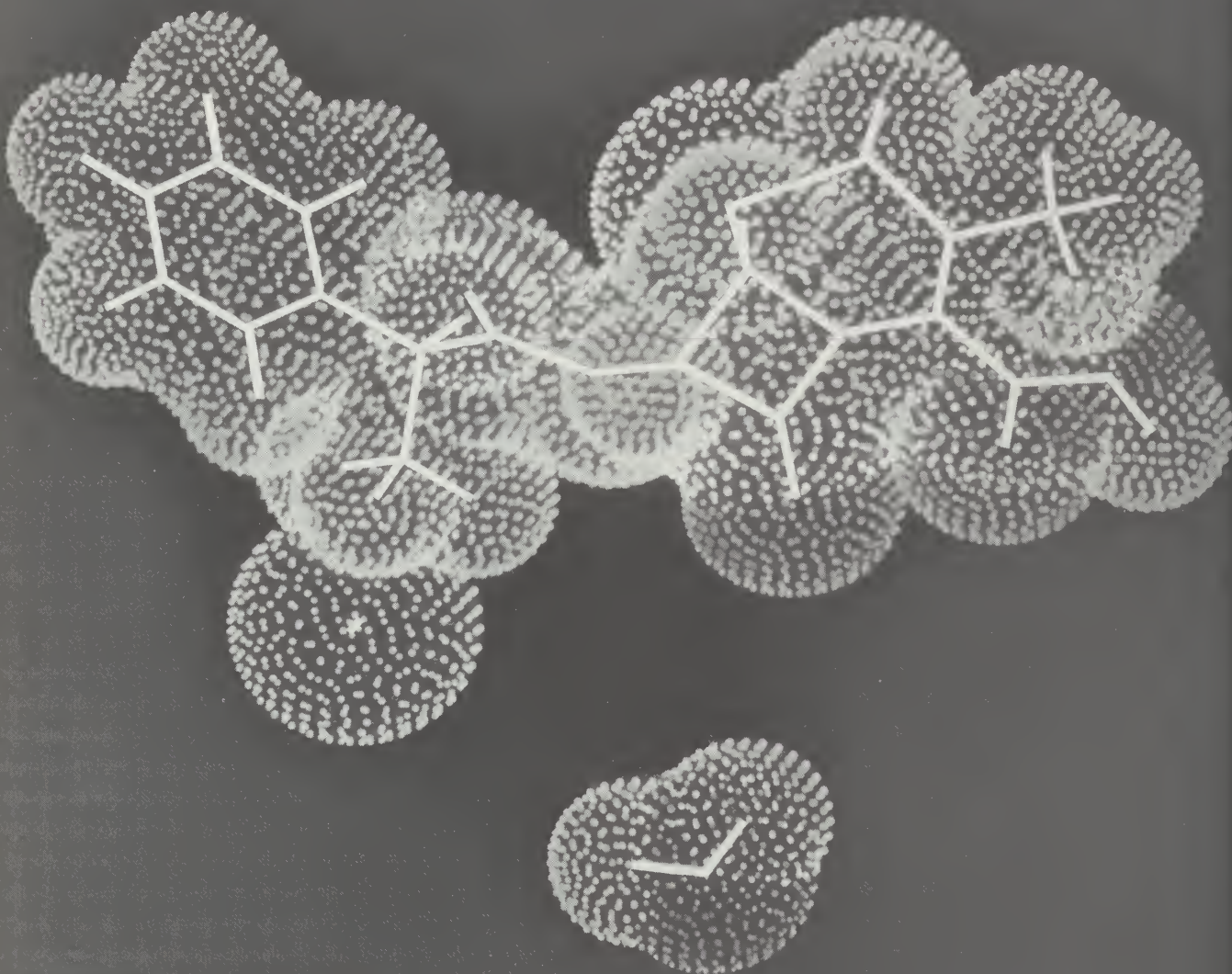
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- Discontinue Keftab in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Keftab should be administered cautiously in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy and lactation. Cephalexin is excreted in mother's milk. Exercise caution in prescribing Keftab for these patients.
- Safety and effectiveness in children have not been established.

Adverse Reactions:

- *Gastrointestinal*, including diarrhea and, rarely, nausea and vomiting. Transient hepatitis and cholestatic jaundice have been reported rarely.
- *Hypersensitivity* in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson syndrome, or toxic epidermal necrolysis.
- *Anaphylaxis* has been reported.
- *Other reactions* have included genital/anal pruritus, genital moniliasis, vaginitis/vaginal discharge, dizziness, fatigue, headache, eosinophilia, neutropenia, and thrombocytopenia; reversible interstitial nephritis has been reported rarely.
- Cephalosporins have been implicated in triggering seizures, particularly in patients with renal impairment.
- *Abnormalities in laboratory test results* included slight elevations in aspartate aminotransferase (AST, SGOT) and alanine aminotransferase (ALT, SGPT). False-positive reactions for glucose in the urine may occur with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Learning To Fight *Nicotiana tabacum*

JOHN SLADE, MD



The tobacco epidemic is an especially difficult medical problem. Although progress is being made in this country, tobacco remains the leading cause of preventable death, accounting for between 350,000 and 500,000 deaths per year.¹⁻³ Furthermore, cigarette use is expanding in the world

as a whole: since 1960, cigarette consumption has doubled, to 5 trillion units per annum.⁴ In 1987, every 48 minutes, another New Jersey citizen dies because of cigarettes.

BLOCKS TO TREATMENT AND PREVENTION

How did this problem come to be so enormous, and why has this devastating epidemic been so dif-

John Slade, MD, is the Guest Editor of this issue.

ficult to control? At least six interrelated elements have contributed to prolonging this seemingly intractable epidemic:

1. Nicotine is a drug of dependence.⁵⁻⁷ It produces an addiction which usually begins in childhood and is self-perpetuating unless deliberate; sometimes enormous individual effort is expended to develop a program of lasting abstinence. Elaborate defense mechanisms, including denial, rationalization, and enabling, develop around tobacco use once a person loses control of his consumption. The American blend cigarette, introduced in 1913, is the most addictive form of tobacco yet invented.

2. Tobacco was a major part of the economy for three centuries before evidence of harm from its use became conclusive, just over a generation ago. Tobacco helped finance the American Revolution. Its past importance is symbolized by the use of tobacco leaves and flowers as decorations atop columns dating from 1818 in the Old Senate Rotunda of the United States Capitol. Its current importance is suggested by the decorations in the Treaty Rooms at the U.S. State Department, completed in 1986, which employ the same motif.⁸

3. The prevailing social attitudes towards tobacco have been remarkably casual and permissive for several generations. While such attitudes are changing, there remains an incredible, banal ordinariness about the display and sale of tobacco products and their use in public. Most cigarettes (52.5 percent) are sold in grocery stores and supermarkets.⁹ Cigarettes have not always enjoyed this almost indifferent acceptance. Rather, it developed in parallel with the profound increase in cigarette consumption during the present century. In 1911, an editorial writer noted, "Anything that may be done to restrict the general and indiscriminate use of tobacco in public places, hotels, restaurants, railroad cars, will receive the approval of everybody whose approval is worth having."¹⁰

4. Tobacco merchants have continued the aggressive promotion of their products and even expanded into new markets with an astounding indifference to the illness and death which results from the use of their merchandise.¹¹⁻¹⁴ About six cents per pack, \$2 billion each year, is spent marketing cigarettes in this country; about \$50 million of that is spent in New Jersey. The industry continues to insist that tobacco has not been shown to cause harm, and that its use is voluntary.^{15,16} Paradoxically, although these businesses strenuously object to assertions that cigarettes cause any harm, tobacco companies are using federal laws which require mildly worded, inconspicuous warning labels as shields from tobacco product liability. This industry should have voluntarily issued prominent, explicit warnings and avoided promotion of its product or expansion

into new markets as soon as substantial evidence of harm had accumulated until the situation could be clarified.^{17,18}

5. The culture at large has grown adept at overlooking the harm caused by tobacco. When chemical dependence is discussed, tobacco is not on the agenda. For instance, although the Media-Advertising Partnership for a Drug-Free America is presenting the largest public service campaign in the history of American advertising, it is ignoring the leading cause of death from drugs. In 1985, the Drug Enforcement Administration and the National Organization for the Reform of Marijuana Laws estimated U.S. marijuana consumption at around 18,000 metric tons. The 1984 production level for flue-cured tobacco was 375,000 metric tons, and an estimated 312,000 metric tons of Burley tobacco were grown. Thus, the marijuana market is only about 3 percent the size of the tobacco market. Since most states have age of sale laws for tobacco, it is likely that more tobacco than marijuana is sold illegally to those under age 18. Furthermore, tobacco use is one of the important pathways to marijuana use among adolescents.¹⁹ Several observers have noticed the scant attention accorded tobacco in general interest magazines, especially those which carry cigarette advertising.^{12,14,20}

6. Health professionals have been minimally involved in attending to this problem. Even simple, perfunctory advice to patients about tobacco use often is omitted by physicians.²¹ At the public policy level, there are only a handful of small offices in state health departments responsible for tobacco prevention programs, and the national program, the Office on Smoking and Health, is a tiny operation.

TOBACCO USE IN CHILDHOOD

Most tobacco use begins in childhood, and the younger a person is when he first smokes, the more likely he is to become addicted.^{22,23} While a debate rages over whether advertising influences young smokers, it is clear that children metabolize cigarette advertising quite thoroughly, and that the most popular brands among children are those whose ads are most readily recognized by the young.^{24,25} Part of the reason that there are no definitive data regarding marketing influences on those the industry might call "replacement smokers" is that there is no unexposed control group for such a study. I am persuaded that marketing is a critical factor in childhood onset tobacco use.^{11,12}

At the same time they are making critical decisions about experimentation with tobacco, people have distorted beliefs about the subject.²⁶ Teenagers believe that smoking is far more prevalent than it is. Those who smoke or who intend to smoke are more likely than confirmed nonsmokers to believe

that smoking is or would be less harmful to themselves than to other people. The decision to experiment with tobacco cannot be accurately described as an informed choice.

Table 1. Where Do You Get Your Cigarettes? (ages 12-18)

Source	N	%
Friends	52	11.0
Relatives	29	6.1
Buy Them	423	89.6
Other	7	1.5
Total Respondents	472	—

David B. Lambert, Chilton Research Service, personal communication, March 25, 1987.

The greatest period of experimentation with tobacco occurs in an age group to which it is illegal in most states for merchants to sell tobacco products,²⁷ yet it is easy for an underage person to purchase cigarettes, either over the counter or via vending machines.

The Tobacco Institute does not believe that underage retail sales are a big problem. An Institute spokesman commented, "Only 10.4 percent of teenage smokers purchase their own cigarettes."²⁸ The Institute buttresses this surprising statistic with a reference to a respected survey of teenagers and smoking.²⁹ The reference does not contain the cited data, however. The Chilton Research Service found the data (Table 1):³⁰ only 10.4 percent of teenage smokers in this survey do not usually buy their own cigarettes.

The cigarette market among those under age 18 is worth about a half billion dollars per year. An estimate of this market, adapted from work by Joe Tye is presented in Table 2. The smokeless tobacco market in this population is worth an additional \$130 million according to Tye's estimate. Although the tobacco industry claims to not want anyone to smoke before age 21, it sells about \$1.3 billion worth of merchandise to this age group each year.³¹

Since cigarette sales yield a profit of more than 25 percent of revenues, and roughly half of the retail price of cigarettes is received as revenue by the manufacturer, these figures suggest that \$163 million in annual profit as well as virtually the entire future supply of adult smokers are derived from sales the industry claims to not want. If the unwanted profits from these sales were recovered by the states, the Department of Health in New Jersey would have nearly \$4 to \$5 million per year available to mount a program to prevent sales to teenagers. Even so, this budget would be quite modest in comparison to the money devoted to marketing cigarettes in the state.

Based on Table 2, New Jersey smokers under age 18 pay about \$3 million in cigarette excise taxes to New Jersey annually, but this revenue provides no services for the treatment or prevention of nicotine dependence among the young. Another estimate of cigarette consumption in this age group suggests that this group pays more than \$7 million in state excise taxes.³² The actual value is likely between the two figures.

AN INDUSTRY RESPONDS TO CONCERNS

The cigarette industry repeatedly has taken steps to allay public fears about its products and to accommodate, up to a point, problems created by tobacco products. Several examples will illustrate the characteristically cynical approach these companies have taken.

In the early 1950s, new brands of filter cigarettes were introduced as the public became concerned about the evidence that cigarettes caused lung cancer. The P. Lorillard Company first marketed Kent cigarettes in 1952. Advertisements promised "the greatest health protection ever developed."³³ First suspected by Blum,³⁴ it now is clear that the Micronite filter in Kent cigarettes delivered this "health protection" by its filtering agent: asbestos.

A Kent advertisement boasted that its filter proved the most efficient in a test conducted by the American Medical Association³⁵ that compared three brands; the most effective filter was the one composed of asbestos and paper.³⁶ One article identified the form of asbestos in Kent as crocidolite.³⁷ At least one case of asbestosis in a worker exposed at the Lorillard filter factory has been reported.³⁸ It is unclear how long asbestos continued to be used in the Micronite filter, but by the early 1950s asbestos manufacturers knew it to be harmful.³⁹

An international tobacco industry conference and exhibition was held in Richmond, Virginia in September 1986; exhibitors for flavoring companies discussed a number of important changes in cigarette additives in recent years. While there presently are no regulations which restrict what can be included in a commercial tobacco blend, there has been some effort to require that a list of ingredients be shared with government officials. Perhaps in anticipation of such rules or against the possibility of even more stringent controls or widespread disclosures, the cigarette manufacturers have re-examined all of the additives used to insure that they are "food quality"; that is, that they are considered safe for addition to food products. This has meant that such traditional additives as deer tongue leaves have been eliminated from tobacco blends because the ingredient which gives the vanilla-like flavor to this herb is coumarin.

In addition, a panel of toxicology consultants supervises the testing of potential additives to insure

that such ingredients do not produce harmful substances when burned. The experimental work involved in such tests frequently is performed by laboratories in other countries; the result, if unfavorable, might be difficult to discover in United States legal proceedings. It is likely that tobacco itself would not pass the testing panel's standards for additives.

In a cigarette factory, conveyer belts move vast quantities of tobacco around from place to place. Such belts may become frayed, so bits of belting can be incorporated into the tobacco blend. Because manufacturers are concerned lest any toxic gases or particulates arise from the combustion of bits of conveyer belting, all such belts now are made of materials which produce nontoxic fumes when burned. The same standard has not been applied to the main ingredient.

The new generation cigarette-making machines is capable of producing 8,000 cigarettes per minute (cpm). These \$660,000 devices replace machines which churned out 4,500 cpm. A machine manufacturer salesman indicated that Philip Morris had asked his company to design a cigarette maker capable of operating at 14,000 cpm. This continued push for improvements in technical wizardry from an industry whose domestic sales are steadily declining seems puzzling, except for the fact that cigarettes are a growth market in most of the world because of continual, aggressive marketing by these same companies.^{4,12,13}

WHAT CAN THE PHYSICIAN DO?

What can be done in this grim circumstance? There are many opportunities to make a positive impact on this situation. Here are suggestions which physicians can work for at the public policy level, and suggestions which can be adopted in clinical practice.

Public Policy: Government must accord tobacco the attention it deserves. In each state, an Office for the Treatment and Prevention of Nicotine Dependence should be established and supported. Without support from concerned health professionals and citizens, this proposal will not flourish because of the perceived political risks involved. Such an office, funded by the cigarette excise tax, already is a reality in Minnesota.

Second, children must be protected. The report of the Commission on Smoking or Health in this issue addresses many of the measures needed to accomplish this. The report of the Commission on Smoking or Health appears on page 151. Private initiatives are needed as part of this effort. The California Medical Association has appropriated \$50,000 to address the problem of children and tobacco.

Third, places where medical care is given must be free of tobacco. There are two major challenges here: smoke-free hospitals and tobacco-free pharmacies. The Medical Society of New Jersey has called for legislation to ban smoking from all acute-care hospitals, and hospitals are moving voluntarily in this direction. Pharmacies undermine their role as health care providers if they also sell tobacco products.^{40,41} Tobacco-free pharmacies can be found in most counties of the state; more pharmacies should be encouraged to join their ranks.

Clinical Practice: Physicians should regard nicotine dependence as an illness in and of itself, instead of a mere risk factor for disease. Physicians should learn how best to help their nicotine-dependent patients become abstinent from tobacco. The most important elements (forging a therapeutic alliance, taking a history, educating the patient, developing a specific treatment plan, planning follow-up, and referring when appropriate) are identical in form to the way hundreds of other diseases are managed. To date, though, medical education usually

Table 2. Estimated Cigarette Sales to People 21 Years of Age or Younger

Age Group	Population (Millions)	% In School	Smoking Among Those in School (%)	Total Smokers (millions)	Packs Per Week	Annual Sales at \$1.25/pack (millions)
10-13	13.0	98	5	0.65	1	42.3
14-15	7.4	95	15	1.17	2	152.1
16-17	7.2	85	18	1.49	3	290.6
18	3.7	80	20	0.89	4	231.4
Total	31.3			4.20		\$716.4*

Adapted from analysis by Joe Tye. Population data: U.S. Vital Statistics, 1986. Smoking rates: extrapolated from Johnston LD, O'Malley PM, Bachman JG: Drug use among American high school students, college students, and other young adults, National Institute on Drug Abuse, 1986. Dropout rate estimated. Smoking assumed to be twice as prevalent among dropouts.

*Sales to those under 18 are \$485 million. About 7.9 million people are in the age group 19-20. If 30 percent of these people smoke an average of 4 packs per week, this group spends \$616.2 million per year on cigarettes. The total sales of cigarettes to those under 21 is on the order of \$1.3 billion.

has not provided instruction or exemplars of this approach to treating nicotine dependence. Physicians should be alert to protect nonsmokers from tobacco smoke, not only by encouraging clean-air policies in public places, but also by supporting clean-air initiatives in the homes of nonsmoking patients. This especially is important for children. In a related matter, nonsmokers should be encouraged not to enable the nicotine dependence of those around them by such activities as cleaning out

ashtrays or purchasing tobacco products.

SUMMARY

Tobacco is responsible for the largest epidemic of the 20th century. The tobacco industry devotes enormous time, intellectual energy, and money to maintaining tobacco's place in the culture. Unless the medical community mounts a focused and intentional campaign to control tobacco, this scourge will continue to devastate our patients. ■

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Burlington
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Camden County

Al-Rose Apothecary
Camden
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Cherry Hill Pharmacy
Cherry Hill
(609) 667-8700
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Cherry Hill
(609) 429-8700
Towne Pharmacy
Merchantville
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Essex County

Hasler's Pharmacy
Caldwell
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The Medicine Shoppe
Nutley
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Gloucester County

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Glassboro
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The Medicine Shoppe
Trenton
(609) 883-7062

Middlesex County

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Jamesburg Pharmacy
Jamesburg
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The Medicine Shoppe
Parlin
(201) 727-0993
The Medicine Shoppe
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(201) 754-0707
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Woodbridge
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Wernick's Pharmacy
Metuchen
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As a public service, New Jersey Group Against Smoking Pollution will publish updates of this list as additional tobacco-free pharmacies are reported. Send notices to N.J. GASP, 105 Mountain Avenue, Summit, NJ 07901, or call (201) 273-9368.

Side Effects of Nicotine Dependence

JACK E. HENNINGFIELD, PhD



Most of the over 50 million Americans who smoke cigarettes know that they are exposing themselves to toxins that can lead to cancer and other diseases. The majority of these people would like to quit, and most try, repeatedly.¹ Data from the U.S. Public Health Service show that nearly 20 percent of those who try to quit smoking may succeed on their first attempt, and, by their seventh attempt, nearly 40 percent will have quit—and that is the good news. The bad news is that more than 60 percent will have been unsuccessful.² Clearly, to expose oneself on a daily basis to a known toxin

is not a simple, voluntary behavior of free will and pleasure. Of course, some people are able to quit, with seemingly little difficulty; these are the fortunate. For the rest, successful long-term abstinence from tobacco products at least may be a brief struggle; for others it will be a life-long trial, and for some it may be an impossible task.

Tobacco-related carcinogen exposure is a side effect of nicotine dependence. Why is there such clock-like, day-in/day-out, self-exposure to a source of cancer known to nearly all who smoke? Why is it that many who have quit have recurrent cravings for what they had considered to provide an important source of pleasure? Is there any physical basis to the claims of some who feel they are not as effective at work or as effective at coping with stress since they have given up tobacco? These sequelae, and others, of quitting are not simple responses to a change in habit. They are part of the addictive pro-

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cess that the U.S. Public Health Service, the Surgeon General, the American Psychiatric Association, and many others believe underlies the compulsive use of smoked and smokeless tobacco products.^{3,4}

The nicotine dependence process is a major impediment to the reduction of cancer and other tobacco-caused diseases. Reducing the exposure to many carcinogens is achieved simply by removing them from the workplace, using protective clothing, and filtering air and water. However, reducing the exposure to tobacco-borne carcinogens can be much more difficult since it usually occurs as a side-effect of nicotine dependence—and nicotine dependence can be powerful, as attested to by the heroin addicts who can give up narcotics but not tobacco.⁵ Recent studies have confirmed that, mg for mg, nicotine is more potent than cocaine in modifying behavior; it is as powerful and more potent than most barbiturates in causing physiologic effects that can be fatal; tolerance to behavioral and physiologic responses is as pronounced as that which occurs with the heroin-like narcotics. Whereas initial use can be intoxicating, subsequent higher levels of use are not associated with clear behavioral disruption. These findings are scientific proof of what has been suspected for many years—that nicotine is an addicting drug. Nicotine is not an innocuous ancillary constituent of tobacco. Nicotine is the single most critical element of the interface between tobacco carcinogens and cancer. Without nicotine, there is no evidence that there would be widespread com-

pulsive use of the most important preventable cause of death and disease. Unlike the flourishing market of decaffeinated beverages, of sugarless sweeteners, and of low-salt foods, denicotinized tobacco products have never sustained interest or provided continuing profit in the marketplace.

Nicotine dependence even limits efforts to simply reduce carcinogen exposure. The control levied by nicotine is so powerful that attempts by health-minded persons to reduce their risk of tobacco-related disease by reducing the number of cigarettes they smoke, or by switching brands, are thwarted by their need to maintain a minimal nicotine intake.^{6,7} This results from the processes of physical and behavioral dependence. These processes interact with the powerful, behavior-controlling features of nicotine that sustain the compulsive self-administration of a toxic substance.

The rest of this paper will describe some of the recent data regarding the mechanisms by which nicotine enables tobacco to take control over the behavior of those exposed. As should become evident, our understanding of such findings give cause for renewed hope for reducing exposure to tobacco-borne toxins.

A BEHAVIORALLY ADDICTING DRUG

That occasional use of tobacco could lead to compulsive, regular use has been known for centuries, as reported in various historical accounts.⁸

As described in basic pharmacologic textbooks, it

has been known for decades that the nicotine delivered when tobacco products are used is a potent and powerful drug which can control behavior and modify physiologic functioning.⁹ In 1942, Dr. L.M. Johnston suggested that "smoking tobacco is essentially a means of administering nicotine, just as smoking opium is a means of administering morphine."¹⁰ He had found that intravenous injections of nicotine could mimic many of the behaviorally important changes in mood and feeling produced by inhalation of tobacco smoke. More recently, Johnston's observations have been replicated and extended, leading to the conclusion that the role of nicotine in the tobacco dependence process is equivalent to the roles of drugs such as morphine, cocaine, and ethanol, in the dependencies to opium products, coca derivatives, and alcoholic beverages, respectively. Tests of nicotine have been conducted using the same procedures developed to evaluate the opioid narcotics (morphine and heroin), psychomotor stimulants (amphetamines and cocaine), and sedatives (barbiturates and alcohol). Even though, by definition, every drug is unique, testing drugs for their ability to addict users is a process of identifying critical common features, i.e. establishing pharmacologic equivalence. Nicotine has proved positive on all critical elements of these tests, as shown below:

Nicotine is a psychoactive drug. Analogous tests in both animals and humans have confirmed that nicotine has direct effects in the central nervous system that can lead to controlled behavior. The effects are dose-related and can be blocked by centrally acting nicotinic blockers, e.g. mecamylamine. Central nicotinic receptors, as well as changes in regional brain glucose utilization, appear important in the mediation of these effects.^{12,13}

Nicotine can alter mood and feeling state. Standardized tests have been used to confirm that nicotine can produce desirable elevations in mood state as can other addictive drugs under comparable conditions. These effects include dose-related increases in ratings of drug liking scores; they are sometimes termed "euphoriant" effects.¹¹ Nicotine also can alleviate certain undesirable states such as anxiety and boredom;¹⁴ such "useful" effects can enhance the strength of the addiction.

Nicotine can modify (condition) behavior. Analogous tests in both animals and humans have confirmed that nicotine can serve as a positive reinforcer (reward) which conditions behavior and thereby results in repetition of the behaviors which lead to the administration of the drug.¹⁵ Nicotine, in the tobacco vehicle, appears to provide an ideal source of drug reinforcement and its efficacy is increased by a range of conditions including anxiety, stress, and hunger.¹⁶

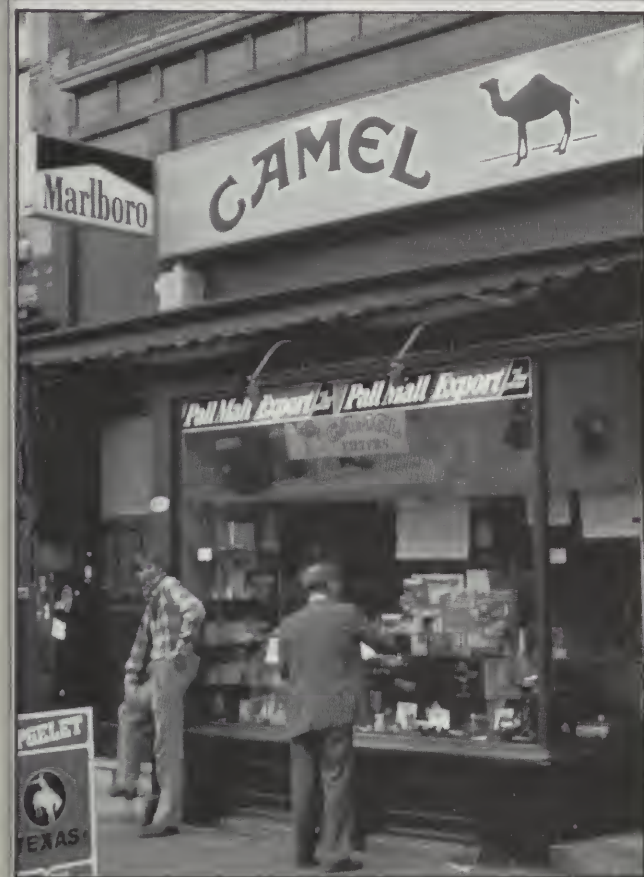
The results of studies using these strategies con-

firm that nicotine is a drug that shares critical features with other dependence-producing drugs. It has noteworthy multiple and malleable properties to serve as stimuli, to produce desirable changes in mood and feeling state, and to serve as reinforcers when the dose is "just right" (easily attainable by the so-called "finger-tip" dose control over the cigarette), and even to restrain behavior by aversive higher dose effects. These various effects of nicotine allow it to shape, steer, prod, and pull the behavior of the user down the path of dependence. It also is important to understand that these effects of nicotine are real and physically based. The behavior-controlling actions of nicotine are due to specific effects of nicotine on receptors and transmitters in the central nervous system and to the regulation of hormonal function; the effects of nicotine are dose dependent; they show orderly patterns that follow a regular course of onset and offset (pharmacodynamics); and the effects are related in a complex but orderly fashion to blood nicotine levels (pharmacokinetics). Of course, nicotine dependence is even more than this: chronic exposure of hormonal systems and tissue of the central nervous system results in adaptation to the pressure of nicotine and to physiologic dependence.

A PHYSIOLOGICALLY ADDICTING DRUG

Drugs can be addictive to their users whether or not they cause physical dependence, but when their characteristics are such that they readily take control over behavior and cause physical dependence, the resulting addiction can be highly pernicious. Nicotine does both. Physiologic or physical dependence generally is thought to result when tolerance (diminished responsiveness) develops to repeated drug use. Behavioral and physiologic functions then adapt to the presence of the drug and may be disrupted if the drug is abruptly removed. Just as there are standard tests to evaluate whether or not drugs cause behavioral dependence, there also are standardized methods to evaluate whether tolerance and physical dependence occur when a drug is repeatedly given.

Tolerance. Tolerance to nicotine has been studied using a variety of measures of behavioral and physiologic functioning over the decades.¹⁷ A survey conducted at the Johns Hopkins University School of Medicine confirmed one likely consequence of such tolerance development. That study showed that the course of development of tobacco dependence follows an orderly pattern of daily dose graduation in which most people begin at a level of only a few cigarettes per day.¹⁸ These findings are consistent with those which showed that adolescents actually obtain more nicotine per cigarette as they grow older and presumably have smoked longer.¹⁹



Rotterdam 1986

Physical dependence. Confirmation that physical dependence was produced by nicotine has been obtained in a series of studies by Drs. Hughes and Hatsukami. In an elegant series of studies, these researchers have studied the physiologic dependence that can develop when nicotine is taken in the form of cigarette smoke, smokeless tobacco, and nicotine polacrilex (chewing gum).²⁰ Two of the main findings were: an orderly syndrome of physiologic and subjective responses follows abrupt termination of nicotine administration, and withdrawal from nicotine is qualitatively similar, regardless of the vehicle employed. Studies by other researchers have obtained many of these same kinds of findings and also have shown that the severity of the tobacco withdrawal syndrome is related directly to the dose of nicotine to which the person had been taking. A series of studies conducted at the Addiction Research Center has verified the following additional findings: withdrawal includes objectively measured deficits in ability to perform tasks such as logical decision making and arithmetic; the onset of withdrawal-associated changes in electroencephalogram (EEG) activity; and deficits in performance occur within hours of the last cigarette and may persist for at least ten days (the duration of observation during abstinence in this study).¹⁸ Therefore, it is not clear how long physiologic withdrawal lasts.

Treatment of tobacco withdrawal with nic-

otine. The observation that an alternate nicotine delivering formulation can at least partially substitute for tobacco opened the door to the use of nicotine in a therapeutic modality, much as benzodiazepines can be used to help manage alcohol withdrawal, and methadone can be used to manage heroin addiction. At present, the only commercially available formulation for the treatment of tobacco dependence is the nicotine polacrilex (chewing gum).^{22,23} Studies at the Addiction Research Center showed that use of nicotine gum could block the withdrawal-associated behavioral performance deficits, EEG changes, and most other signs and symptoms.¹⁸ The effect of the gum was especially impressive since the volunteers did not actually "like" the gum. The withdrawal-related measure that was not affected by nicotine was "desire to smoke." This finding is analogous to that found in other forms of drug dependence when replacement therapy is used. It is compatible with the notion that "desire" is a behavioral response that is only partly determined by pharmacologic state. Therefore, the main therapeutic action of nicotine gum would seem to be in the alleviation of physically based signs and symptoms of withdrawal, but not necessarily in blocking the desire to smoke.

Work by many investigators has confirmed that nicotine replacement is a useful adjunct when used with effective therapies in treating tobacco dependence. In fact, nicotine gum not only meets the criteria of therapeutic efficacy and low toxicity, but it also seems to have a relatively low potential for abuse. Thus, it is easier for most people eventually to quit using the nicotine gum than to quit using tobacco.

CONCLUSIONS

It now is overwhelmingly clear that tobacco-delivered nicotine has a substantial role, albeit indirect, in the cause of cancer and other tobacco-associated diseases. Cancer and other diseases can be caused by repeated exposure to certain toxins: the nicotine dependence process insures that such exposure will be frequent and chronic for many people, and that their attempts to eliminate, or even to reduce, such exposure may be thwarted by their dependence upon nicotine. But nicotine itself also may be used therapeutically to reduce such toxic exposure, since it is the tobacco vehicle which is the primary source of tobacco-related carcinogens. Thus, if the nicotine vehicle or formulation is changed to a nontoxic one, the health hazard can be substantially reduced.²²

The fact that certain elements of withdrawal or emergent symptoms, e.g. anxiety or weight gain, may persist indefinitely in some people suggests that these persons are at life-long risk for resumption of high-level carcinogen exposure. For these persons,

extended or possibly even life-long access to nicotine replacement may be necessary. Fortunately, there is little evidence that the currently available nicotine gum formulation is likely to be used by those not initially dependent upon tobacco-delivered nicotine. Therefore, it would seem that a substantial reduction in the overall level of health risk to our population may be accomplished by the adjunctive utilization of nicotine replacement.^{22,24} In addition, it should be useful to develop new nicotine replacement formulations for those who cannot use nicotine-delivering gum. This could constitute a major additional step in the elimination of tobacco dependence, and subsequently, nicotine dependence in those for whom the tobacco-to-therapeutic formulation transfer was accomplished. It could be an equally great contribution in reducing the exposure

to known carcinogens.

A caveat in the pharmacologic treatment of tobacco dependence is that development of alternative replacement approaches should be constrained by abuse liability testing to prevent formulations from being marketed which could result in new forms of nicotine abuse that were not initiated by tobacco use.²⁶ There is no evidence that the gum formulation is attractive to nontobacco users. However, it would seem possible to produce nontobacco nicotine-delivering formulations that are as addictive as the tobacco versions. It also appears that the potentially valuable oversight of the Food and Drug Administration might be avoided by marketing new nicotine-delivering formulations that may be addictive as well as causing cancer by their containing a small percentage of tobacco. ■

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C I B A

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1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.
2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure; hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS

Hyperkalemia (See OVERDOSAGE).

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS

General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients

Physicians should consider reminding the patient of the following:

To take each dose without crushing, chewing, or sucking the tablets.
To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.

To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions

Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions will be present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, excretory mechanisms are impaired or if potassium is administered rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Manifestations include muscle paralysis and cardiovascular collapse for cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 mEq of 10% dextrose solution containing 10-20 units of insulin per 1,000 mL; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Doses must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

HOW SUPPLIED

Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, but colored, sugar-coated (imprinted Slow-K)

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Consumer Pack—One Unit

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Do not store above 86°F (30°C). Protect from moisture. Protect from light.

Dispense in tight, light-resistant container (USP).

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YOCON®

YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

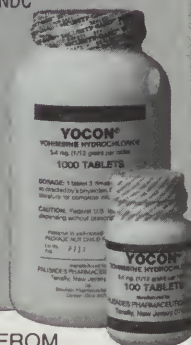
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

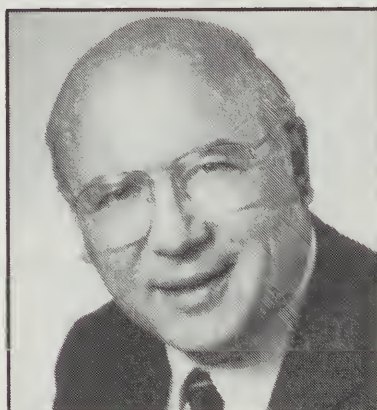
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Smoking Cessation in Primary Care Settings

C. TRACY ORLEANS, PhD



A cyclical model for quit smoking treatments in primary care settings is based on studies of primary care quit smoking interventions¹⁻⁵ and on research showing quitting smoking is a self-change process.⁶ The four major stages through which a quitter may cycle on any given attempt are: precontemplation, contemplation (deciding to quit), action (preparing to quit and quitting), and maintenance of nonsmoking. Strong support for quitting as a multistage process dictates that primary care strategies involve persistent efforts over repeated contacts, not just "one-shot" interventions.

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The proposed model outlined in the Figure incorporates elements of triage and staging into a stepped-care approach that offers smokers more specialized or intensive help as they progress through the various stages of smoking cessation, e.g. precontemplation-contemplation-action maintenance or "recycling," or through repeated quit attempts.⁷ Specific suggestions are made for: creating a practice en-

vironment that encourages nonsmoking and minimizes barriers to quit smoking interventions; and providing a variety of opportunities for smoking patients to acquire, over time, the motivations, skills, and supports for successful smoking cessation. Practical suggestions are given for physicians and allied health care providers functioning in a variety of primary health care settings, e.g. solo practice, small-group office practice, HMO, public health, hospital clinic.

A FACILITATIVE PRACTICE ENVIRONMENT

As the Figure shows, several steps are involved in creating a facilitative practice environment. Smokers must be identified and recruited to treatment.⁸ Inquiring about smoking status can be done as part of the routine assessment of vital signs. Notation should be made in the charts of all patients needing quit smoking treatment (smokers, recent quitters, or relapsers). Many quit kits designed for office practice include chart stickers for this purpose. Of course, smokers can be recruited into practice-based or community quit smoking treatments through posters and announcements placed in the practice or sent through the mail.

There should be visible evidence of a nonsmoking orientation in the practice with "Thank You for Not Smoking" signs prominently posted. The smoking ban must apply equally to patients and staff. Ex-smokers on the staff might wear "I Quit" buttons to identify themselves as resources for smokers planning to quit. Patient education materials should be displayed in waiting and treatment areas.

Most physicians and allied health care staff need to be motivated (or remotivated) and trained to intervene effectively. Although physicians view smoking as a very serious health risk and feel responsible for helping their patients quit, national surveys show that only two-thirds of physicians routinely advise most of their smoking patients to quit, and fewer than one-quarter of physicians regularly offer systematic treatment in their practices or suggest outside referral.^{9,10}

Pessimism about patients' abilities to quit smoking, physicians' lack of training or lack of confidence in their own counseling skills, and a lack of confidence in outside treatments are cited as the major obstacles to more aggressive antismoking efforts.^{9,11} This pessimism is not surprising given that physicians are likely to have "failed" often in the past; the typical primary care intervention is likely to have motivated smokers to try to quit, but not to have supplied the patient with the skills or supports necessary for lasting behavior change.^{9,12}

Physicians need to learn to use cost-effective backup self-help and intensive behavior change treatments. Moreover, physicians need to set realistic goals for their efforts in order to keep a positive outlook, i.e. if treatments succeed in getting 1 out of 10 smokers to quit, this would more than double the annual national quit rate of 2 to 4 percent.¹³ Unfortunately, medical school curricula usually do not offer training in medical quit smoking counseling and referral.¹⁴ Up-to-date training is motivational and behavior change strategies will be a prerequisite for quit smoking programs in most primary care settings. Such training can be accomplished in brief CME-type sessions.^{1,15}

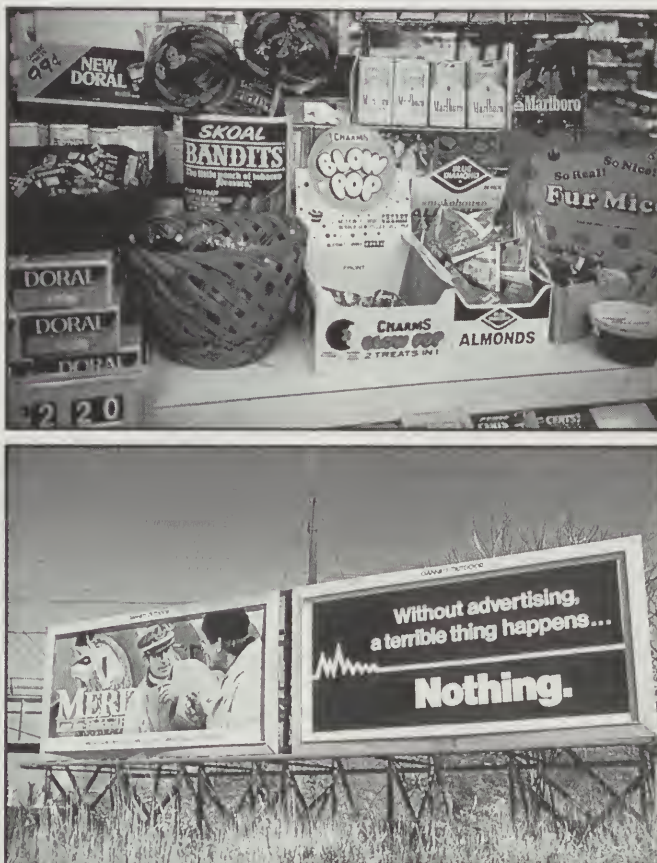
It is essential that organizational, financing, and staffing barriers to quit smoking intervention be removed or minimized. Important practical barriers physicians often cite include: lack of time; lack of coordination between the primary care setting and

community-based quit smoking programs and resources; and lack of third-party reimbursement for smoking cessation counseling.⁹ Emphasizing minimal contact treatments and relying on allied health care staff for more time-consuming counseling and follow-up, will minimize demands on physician time. Maintaining an up-to-date roster of state-of-the-art community programs/resources, and routinely following up on patients referred to these treatments, will help to assure greater and more appropriate use of outside treatments. Efforts to secure third-party reimbursement for the treatment of tobacco de-

pendence should be continued.

PRIMARY CARE INTERVENTION

Whether they quit on their own or in a formal treatment program, smokers are more likely to succeed if they possess quitting motivations and expectations, employ certain quitting and self-management skills, and can draw on social support and psychosocial resources in their efforts. Table 1 summarizes these factors, incorporating the smoking habit variables associated with successful quit-



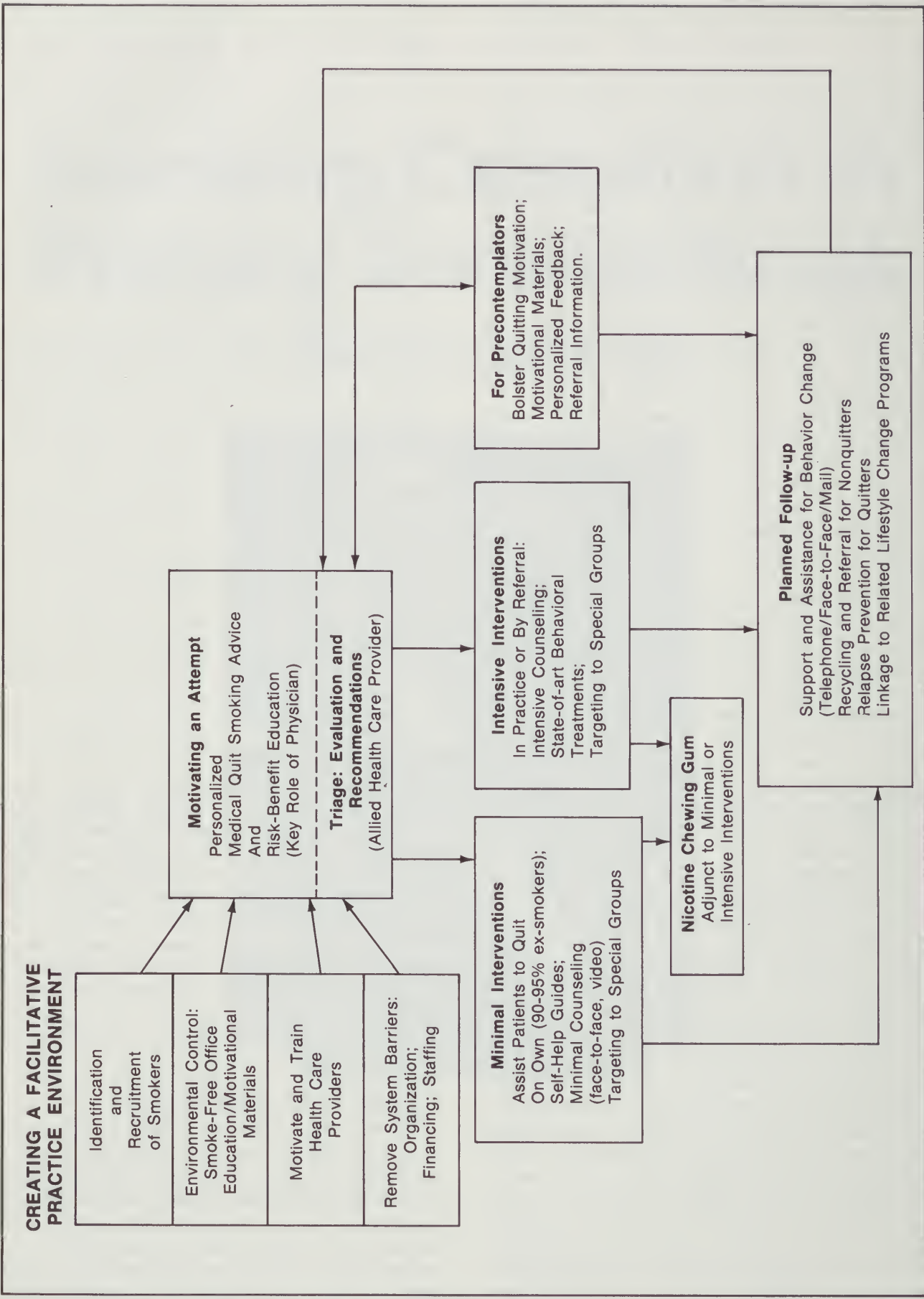


Figure. Model for a primary care smoking cessation initiative.

ting.^{2,12,16-22} The most effective primary care interventions will be those that: 1) equip smokers with these requisite motivations, skills, and supports, and 2) help smokers deal with quitting obstacles, and with aspects of their smoking habit and general health lifestyle that might present special difficulties. The provider can use Table 1 as a "check-list" to guide personalized risk education/advice and to help select an appropriate initial quitting program, and any needed adjunctive treatments, e.g. weight control, stress management training.

1. A Cyclical Stepped-Care Treatment Model. Primary care interventions start with personalized medical quit smoking advice and risk-benefit education (Figure). The purpose of this initial step is to enhance quitting motivation among smokers, both contemplators and precontemplators, setting the stage for a serious quit attempt.

The single most important reason people have for quitting smoking is concern over their health, and smokers who quit for health reasons are more likely to succeed.^{5,18,19-22} Feeling personally vulnerable to smoking health risks and being troubled by reversible smoking-related symptoms (like coughing, wheezing, and shortness of breath) are especially likely to cause quit attempts.¹⁹⁻²² To enhance health motivation, physicians should offer straightforward risk-benefit education, informing the smoker of his/her personal health risks from continued smoking, highlighting any present smoking-related symptoms or illnesses, and emphasizing the health benefits of quitting smoking.^{3,19,21} Health risk information should be conveyed matter-of-factly, without scare tactics that can boomerang creating high levels of anxiety that may lead to increased smoking. Since medical advice is likely to carry the greatest weight coming from a physician, the physician should play the key role in this brief motivating intervention.

After reviewing personal health risks and benefits, physicians should talk with patients about their interest in and motives for quitting, and about any past quit attempts or obstacles. The facts are that 90 percent of smokers would like to quit, 60 percent have tried, and 66 percent are concerned about personal health harms.^{19,23} Hence, most smokers already are contemplating quitting. Reviewing past attempts gives valuable opportunities to assess and bolster quitting motivation, and will help to indicate the most appropriate treatment plan. For instance, brief probing will reveal whether past difficulties involved initial withdrawal difficulties, longer-term negative side-effects (e.g. weight gain, stress), a lack of social support, and/or reliance on ineffective quitting strategies or programs.

Although smokers want to quit, many smokers are likely to have given up on their ability to succeed, or on the value of outside help. Their pessimism

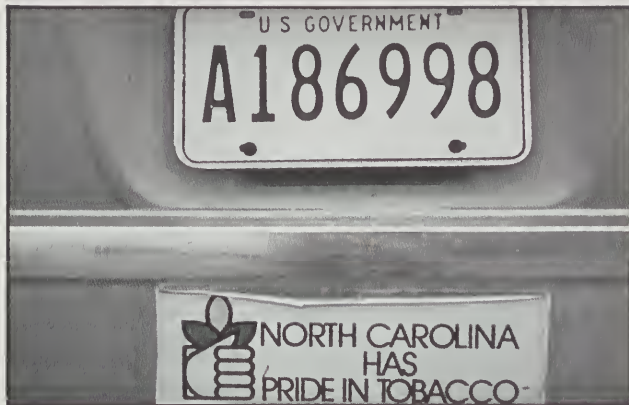


**LUNG CANCER
Will Soon Be The
#1 Cancer Killer Of
American Women**
(BASED ON CURRENT PATTERNS OF SMOKING)
AMERICAN CANCER SOCIETY

Poster from The American Cancer Society, 1981.

springs from unsuccessful past attempts, too often with products and programs that have no demonstrated ability to help them—e.g. free health education clinics, one-shot hypnosis, acupuncture, filters, lozenges, and untested self-help guides or treatments.^{16,19,23,24} Since successful quitters possess greater self-mastery motivation and quitting confidence, medical advice should seek to bolster both. Like their physicians, smokers need to be re-motivated. Past "failures" should be re-interpreted as evidence of serious quitting motivation in the absence of needed support, skills, and resources. It should be explained that quitting usually involves "trial and error" learning over repeated attempts that most successful ex-smokers made more than one attempt before succeeding, and that most smokers who try to quit eventually do succeed.²⁵

Successful quitters expect quitting to be easier and expect more benefits from quitting than do continued smokers or recidivists.^{5,16,18,21} Many smokers try to quit, often relapsing in the face of strong unpleasant physical and emotional withdrawal reactions. Medical advice should emphasize that withdrawal effects—cigarette cravings, impaired productivity and concentration, irritability, disturbed sleep, productive coughing—are transient and fol-



lowed by many long-term improvements in mood and well-being. Specifically, smokers need reassurance that these symptoms are temporary and can be eased with behavioral coping tactics such as deep breathing and nicotine chewing gum.²⁶

Fears that commonly deter smokers from trying to quit also should be addressed: weight gain, an inability to relax, and a persistent sense of loss. Patients need to know that weight gain is not inevitable and generally averages less than ten pounds; weight gain can be avoided or reversed with standard strategies for cutting caloric intake and increasing exercise.^{5,18,19,27} State-of-the-art behavioral quit smoking programs include guidelines for limiting or preventing weight gain through low-calorie snacks, dietary restraint, and regular exercise.^{28,30} Although smokers believe they need cigarettes to relax, much of the relaxing effect of smoking is relief from nicotine withdrawal and associations with relaxing activities often paired with smoking, such as taking a break or being with friends. Again, standard behavioral treatments teach alternative ways to relax, and introduce exercise as a stress management aid.^{28,30} Finally, smokers fearing a lasting sense of loss or sadness after quitting should be advised that these reactions generally do not persist. In fact, within the first year of quitting, ex-smokers report less anxiety and depression, better control over their health, and less frequent use of drugs or alcohol to relax.²⁷ However, since smokers experiencing high levels of stress or depression would be expected to have a harder time with initial withdrawal reactions, deferring a quit date until life stress and depression are under better control is wise, unless medical need to quit is urgent.

Medical risk/benefit education should culminate in firm, unambiguous advice to quit smoking, with a clear offer of assistance. For instance, the physician might say: "I strongly recommend that you quit smoking to avoid (more) serious health consequences. If I give you some help, are you willing to set a quit date and give it a try?" Most smokers will accept this offer, leading directly to the step of selecting an appropriate treatment, setting a quit

date, and arranging planned follow-up. However, smokers who still are in the "precontemplation" stage may not.

2. Selecting a Treatment.

Triage. After the physician has elicited a quit smoking commitment, the next step is to select the appropriate behavior change treatment. The physician (or allied health provider) should review the treatment options, taking into account the patient's preferences and any specific quitting needs revealed in preceding discussion of quitting barriers and past quit attempts.⁷ The smoker should be involved actively in making an informed treatment choice. Then the treatment of choice should be reviewed in enough detail that a definite quit date and follow-up date can be established.

The physician may be able to make a confident recommendation based on the preceding interview evaluation, but an additional evaluation (interview or questionnaire) of smoking patterns and quitting needs also could be conducted. If further evaluation is warranted, it might be handled by another staff member who has the time and training for this activity. In fact, at the triage step, the physician may want to turn the patient over to a staff member who would review the chosen treatment with the patient, set a specific quit date and follow-up date, and offer minimal counseling.

When to start with minimal intervention. Minimal self-help interventions provide the best starting point for the majority of smokers. If the smoker prefers a "do-it-yourself" approach, is fairly confident about quitting on his own, appears to have adequate support among family, friends, and co-workers, and has adequate coping skills and resources, triage to a self-quitting program makes sense.²³⁻²⁵ Patients who possess many of the motivations, skills, and characteristics summarized in Table 1 have succeeded in staying off cigarettes six months or more in previous attempts, and those who have achieved success with other self-directed lifestyle changes are especially good candidates for self-quitting.⁷

When intensive treatment may be needed. More intensive face-to-face treatment often is suggested when the patient: expresses a preference for the structure and support a clinic, group, or counselor can provide; has many prior self-quitting and/or formal treatment failures; has very little confidence in his self-quitting ability; lacks adequate social support for quitting at home and work; or has health lifestyle problems or coping skill deficits likely to substantially interfere with quitting.

Nicotine chewing gum? Nicotine chewing gum is suitable as an adjunct to self-help and intensive treatment programs, and should be considered for smokers who appear highly physiologically depen-

dent, particularly heavy smokers (25 or more cigarettes/day), and those who suffered severe withdrawal problems in previous quit attempts. Nicotine chewing gum has been found helpful in reducing nicotine-related withdrawal (e.g. irritability, impatience, anxiety, difficulty concentrating, drowsiness, restlessness) and significantly boosting quit rates of medical and behavioral quit smoking treatments.^{16,31-35} Outcome studies indicate that the benefits of gum use vary in direct proportion to the efficacy of the treatment with which it is paired, and that the gum used alone has no long-term advantage over a placebo.^{12,33} Possible problems of long-term gum dependence by quitters and nonquitters alike indicate the need for careful follow-up to monitor gum use.³⁶

Findings suggest the greatest benefits of nicotine gum are for more highly nicotine-dependent smokers.³⁴ Nicotine replacement would not be appropriate in the face of medical contraindications, e.g. pregnancy, lactation, recent myocardial infarctions, arrhythmias, severe angina, temporal mandibular joint disease or complications (hypertension, peptic ulcer, cardiovascular disease, or insulin-dependent diabetes).³⁸

3. Minimal Interventions: Assisting Patients To Quit On Their Own. Helping patients to quit on their own is the most cost-effective primary care strategy. This involves furnishing the smoker with a state-of-the-art self-quitting guide and providing minimal counseling in self-help quitting/maintenance strategies, including setting a definite quit date and arranging for followup contact. Self-help strategies are reasonably successful; 15 to 20 percent of quitters will still be off cigarettes one year later, and about 60 percent will succeed through repeated attempts over a lifetime.^{13,19,23,25}

Self-help guides/programs. Quit kits and guides suitable for office-based medical interventions are available and contain brief advice on how to counsel smokers, quit smoking prescription pads, office posters, "smoker" labels for charts, and self-help materials for smokers. The quit kits do not offer a comprehensive guide for smokers; therefore, self-quitting guides should be used as supplements. Table 2 lists a number of "quit kits" and guides suitable for primary care intervention.

Self-help guides take quitters through three stages of quitting: (1) contemplation and decision; (2) action; and (3) maintenance of nonsmoking. Most of the guides include support materials for the quitter's friends and family.²⁸⁻³⁰ One program features a segmented home video cassette to be viewed once a day over 13 days while following a concordant viewers' guide.⁴⁰ Prochaska and DiClemente and colleagues have developed a set of quitting guides for each of the stages of quitting.^{41,42}

THANK YOU FOR NOT SMOKING

Patients using these guides after receiving medical advice to quit would be expected to achieve significantly higher quit rates than patients receiving quit advice only. Usual one-year quit rates for medical quitting advice alone are 5 to 10 percent for predominantly healthy patients, 10 to 30 percent for high-risk patients and those with chronic smoking-related illnesses, and 40 to 60 percent for recent myocardial infarction victims;^{1-5,19} these rates are based on results for all smokers, including those who are not thinking about quitting at the time.

Used without medical quitting advice/referral by predominantly healthy, self-selected quitters, the self-help guides would be expected to produce one-year quit rates of about 15 percent.^{30,43} Quitters who select self-help programs probably represent a subset of all self-quitters who feel they need some outside help to succeed. Better outcomes would be expected for patients using these guides following personal quit smoking advice or counseling from a physician.^{30,44}

Minimal counseling. Brief behavior change counseling reviewing self-help materials would be likely to boost quit rates. Two counseling practices appear especially important: advising patients to set a specific quit date and scheduling definite follow-up contacts.^{1,3,7,44} Physicians, office staff, or videotaped presentations may furnish this counseling. An example of an effective minimal counseling strategy comes from a randomized clinical trial with low-income pregnant smokers in a public health maternity clinic.⁴⁶ All women received five minutes of medical advice to quit smoking during their initial prenatal visit. Control subjects received no further assistance; treatment group received standardized ten minutes of counseling in how to quit using the standard American Lung Association self-help guide,²⁸ and a pregnancy-focused treatment group received ten minutes of counseling in using a pregnancy-focused self-help guide. Clinic-based counseling was provided by health educators. Biochemically validated end-of-pregnancy quit rates showed a clear advantage for treatment group subjects receiving brief counseling (6 percent) and materials targeted

to pregnant smokers (14 percent) over control subjects (2 percent).

4. Intensive Interventions. Formal treatment programs and intensive behavior change counseling are important backups for minimal interventions. Intensive treatments in the practice or from outside referral generally offer help beyond that available in do-it-yourself programs, and tend to attract smokers seeking extra help.

Overview of effective intensive treatments. Commercial clinics, noncommercial clinics, and clinics conducted in medical settings usually offer some combination of group support and health education, and teach a variety of behavioral quitting strategies

and nonsmoking maintenance skills.^{5,16,17,19,23} Better programs avoid fear-arousing tactics and emphasize behavioral nonsmoking and self-management skills (relaxation/deep breathing techniques, cognitive and behavioral strategies for coping with withdrawal, resisting or recovering from a slip or relapse, and self-reward). Most of these clinics produce one-year quit rates of 15 to 25 percent with smokers who seek treatment (and therefore may be less likely to quit on their own), rates as good as or better than those achieved by unaided quitters.^{5,16-19,23}

Two research breakthroughs in the past decade have helped to establish treatments with 30 to 50 percent one-year quit rates: (1) the refinement of noninvasive biochemical markers of smoking status (carbon monoxide levels in alveolar breath samples, thiocyanate, and cotinine levels in saliva samples) allowing for objective verification of treatment outcomes; and (2) programmatic research identifying effective multicomponent psychological-behavioral treatments incorporating "aversive smoking" and "nicotine fading" techniques.^{5,16-19,23,24}

One group of effective state-of-the-art treatments combines broad spectrum nonsmoking skill training with "aversive smoking" methods designed to dampen the desire to smoke and fortify resistance to smoking temptations by conditioning an aversion response to the tobacco smoke.^{5,16-19,23} Aversive smoking takes place in two or more five-to-ten minute trials during group or individual treatment sessions: techniques range from potentially dangerous "rapid smoking" to smoking, puffing, or smoke holding no more dangerous than normal smoking. Another group of successful multicomponent treatments incorporates nicotine fading: switching to brands with progressively lower nicotine deliveries over three to six weeks before quitting abruptly in order to minimize nicotine dose and nicotine-related withdrawal reactions.^{30,47-49}

Ongoing research increasingly focuses on reducing the high relapse rates that characterize even the most effective treatments.^{17,23,35,50} Promising new developments include training new quitters to resist relapse temptations and to recover in the face of a slip or setback.^{29,30,42,50} Programs designed expressly for maintainers—to help them remain smoke-free—and for relapsers also are emerging.^{42,51}

Electric shock treatments or films and lectures emphasizing the health hazards of smoking generally are not effective.^{5,19} Hypnosis, surprisingly, still is relatively untested, and commercially available hypnosis treatments often are unaccountable.^{5,19} Chemicals and dietary treatments such as vitamins, bicarbonate of soda, and tranquilizers, and acupuncture have not been found effective.^{5,16-18,23}

Making an outside referral. It is important to be specific in making an outside referral; the physician

TABLE 1. Factors associated with successful smoking cessation.

Motivational factors

- Desire to protect future health and overcome minor smoking-related symptoms.
- Senses personal vulnerability to smoking health risks.
- Desires greater self-mastery, self-control, or self-esteem.
- Has confidence in ability to quit.
- Expects quitting benefits, e.g. health, social, psychological, cosmetic.

Social Supports/Psychosocial Assets

- Personal medical quit smoking advice and follow-up.
- Support and encouragement from family, friends, and coworkers.
- Strong nonsmoking norms in one's immediate social environment.
- Socioeconomic advantage, e.g. education, income, occupation, employment.
- Psychosocial assets, e.g. self-esteem, self-management skills, good stress coping skills, positive health habits, manageable life stress.

Effective Quitting and Maintenance Skills/Strategies

- Preparation for quitting, e.g. monitoring smoking rate, reviewing reasons for quitting, systematic brand switching to gradually reduce nicotine intake before quitting.
- Quitting abruptly on a target date.
- Using a variety of methods to cope with withdrawal symptoms, e.g. deep breathing, positive thinking, concrete cigarette substitutes.
- Using a variety of methods to remain off cigarettes, e.g. avoiding temptations to smoke, finding alternative ways to relax and cope with stress such as hobbies or exercise, using substitute self-rewards to counteract sense of loss and prevent relapse.
- Taking a long-range, problem-solving approach and making repeated attempts in a cumulative learning process.

Smoking Habit Factors

- Lower smoking rate and nicotine intake.
- Less dependence on smoking to regulate negative affect.
- Past success quitting for six months or longer.

should maintain and annually update a list of local quitting programs. Calling the Cancer Information Service (1-800-4-CANCER) and consulting the free guide to national quit smoking programs published by the Office on Smoking and Health may be helpful.⁵²

Offering intensive treatment in the practice. Intensive treatments can be offered in the practice with sufficient staff and resources. In some cases, with sufficiently large patient populations, treatments can be tailored to specific patient groups.⁵³⁻⁵⁸ Hall et al. achieved favorable results with a low-cost six-session treatment designed especially for chronic cardiopulmonary patients: tailored health education was offered with standard behavioral self-help materials and counseling.⁵³ Several promising intensive treatments for pregnant smokers have been developed.^{54,55}

Multisession treatments are likely to appeal to a smaller percentage of smokers because of their greater demands on patients. Hall found a 38 percent drop-out rate among chronic cardiac and pulmonary outpatients recruited for a low-cost 12-session aversive smoking clinic.⁵³ Hughes offered a free 4-session evening program to pregnant smokers who were interested in stopping smoking and receiving treatment: only 1 of 80 patients accepted this offer.⁵⁶ Likewise, very high (50 to 80 percent) drop-out rates have been reported with cardiac patients randomly assigned to multisession group treatments.⁵⁷⁻⁵⁸

In order to recruit a greater number of patients into practice-based intensive treatments, investigators have condensed face-to-face counseling time, and introduced correspondence formats and telephone counseling to cut the number of sessions involved.^{54,55,58} Ershoff and colleagues converted an effective broad-spectrum behavioral quit smoking clinic into an eight-week correspondence course for women receiving prenatal care through an HMO; after a brief introduction by a health educator, participants were sent weekly mailings outlining the quitting program, and were asked to make three calls a week to a telephone answering service for taped message reinforcing the content of each week's booklet. End-of-pregnancy quit rates for pregnant smokers receiving this treatment (28 percent) were twice as high as for usual care controls (14 percent).⁵⁴

Prue converted a successful nicotine fading program for VA hospital outpatients unable to attend hospital-based clinic sessions; smokers were self-referred or referred by hospital staff. Patients were sent weekly installments of a quitting guide and received brief counseling through weekly phone calls from counselors.⁴⁹ Six-month informant-corroborated quit rates (27 percent) compared very favorably to those reported by wait-list control sub-

jects (10 percent) and to those achieved by comparable clinic-based nicotine fading programs.

One-session treatments in the practice represent another promising alternative. In one study, hospital patients referred by their physicians for an intensive professional 60- to 90-minute consultation were supplied with take-home self-quitting guides and contacted twice at six weeks and six months by phone for follow-up counseling and assessment.⁴⁴ These predominantly hard-core smokers received motivational counseling alone (precontemplators) or with guidance in quitting abruptly either with or without "nicotine fading" (contemplators). Results were comparable to those obtained with multisession clinics: a 27 percent six-month quit rate for all smokers (including precontemplators) and a 31 percent quit-rate for those making a commitment to quit and setting a quit date.

5. Treating the Precontemplator. Patients unwilling to make a definite quitting commitment following medical quit smoking advice should be treated and followed up no less diligently than those who are ready to move into action stages (Figure). At the time of initial advice, the patient should receive take-home motivational materials, referral information, and/or a self-help guide, and be invited to contact the office for help when ready to take further action. A low-key nonjudgmental approach is best for helping these smokers move into a contemplation stage, since their resistance to quitting may be, in part, a reaction against coercive or unsympathetic social pressures to quit at home or at work. Motivational materials for precontemplators should address common quitting barriers and challenge popular misconceptions about smoking and quitting. Prochaska and DiClemente have developed a guide for precontemplators, with exercises and personalized feedback to impart "a more balanced view about smoking" and help move smokers into the contemplation stage."⁴¹

It is important not to underestimate the precontemplator's receptivity to nonjudgmental medical advice and assistance. In one study, 25 percent of precontemplators who declined to set a quit date or commit to a definite quitting plan had quit smoking for 24 hours or more within six weeks of an intervention consisting of personal medical advice to quit with motivational counseling, take-home self-help materials, and warning of follow-up. Half of these quitters still were not smoking at a six-month follow-up.⁴⁴

6. Planned Followup.

Warning of followup. Making arrangements for continued contact through followup calls, visits, or letters enhances the effectiveness of physician advice. Russell and colleagues found that one to two minutes of medical quit smoking advice to unse-

lected smokers resulted in a 3.3 percent self-reported quit rate, but a 5.1 percent quit rate occurred among smokers who also received four pages of quit tips and warning that they would be followed up by the practice.³ Cummings et al. found that physicians who routinely scheduled a followup appointment with patients to monitor their progress had a higher percentage of their patients quit smoking after brief office-based counseling.¹

Timing. Regardless of treatment, a simple, personal followup letter from the physician could serve as a cue to action, fostering compliance with anti-smoking advice. This letter should be sent soon after the visit, repeating quitting advice and congratulating the smoker on setting a quit date, starting a treatment, or taking any steps towards re-evaluating or changing smoking habits for the precontemplator.⁵⁹

The best timing of later followup contacts and visits will depend on the treatment chosen. With minimal treatments, a visit scheduled around the time of the quit date may be especially helpful. Quitters enrolled in intensive treatments may benefit more from end-of-treatment visits. Quitters using nicotine chewing gum should be followed regularly for ongoing instruction in gum use, dosage, and eventual fading.³⁶⁻³⁸ Smoking status should always be re-assessed at subsequent medical visits made for any purpose.

Followup counseling. Actual followup contacts provide opportunities for timely personalized counseling, reinforcement, and problem solving. Wilson and colleagues found that three to five minutes of physician advice to quit and brief cessation counseling resulted in 10.5 percent self-reported 6- to 14-month quit rates.⁴⁵ Higher (19.8 percent) quit rates were observed among patients randomly assigned to receive followup appointments at 1, 3, and 6 months for the purpose of reviewing their progress and providing additional counseling. Low-cost telephone followup has enormous potential for use in primary care settings. In a randomized clinical trial of self-help quitting in an HMO, brief counselor follow-up calls boosted compliance and success with a self-help quitting program.³⁰ Self-referred smokers received a behavioral self-quitting guide and supporter brochure either alone, or with two to four expected brief calls from a Quitline telephone counselor and an invitation to call the telephone Quitline for additional counseling as needed. Counselor-initiated calls boosted the 6- to 8-month quit rate by 50 percent: approximately 14 percent of smokers using the guide alone had quit at the 6- to 8-month followup, while 22 percent of Quitline subjects had done so. Though quitters made very few calls into the Quitline, the availability of Quitline counseling was rated as helpful. National and community quit

smoking "hotlines," including the Cancer Information Service 800 telephone line, offer useful adjuncts for primary care interventions.^{43,51}

Followup with quitters/nonquitters. Contacts with quitters should praise their efforts and success, help them identify which behavior change strategies and nonsmoking techniques are working best for them, and assist them with any unwanted quitting side effects. It may be helpful to discuss referral to other lifestyle change programs offered in the practice or in the community to help the new ex-smoker adjust to his new lifestyle, eg. weight control, exercise.

Nonquitters should receive praise for any steps taken towards quitting, and be helped to identify and overcome quitting obstacles and to reach a new quitting plan and quit date. Precontemplators should be encouraged to continue to re-evaluate their smoking habits and overcome motivational

TABLE 2. Self-help quit smoking resources.

Quit Smoking kits for medical settings

- | | |
|--|---|
| <ol style="list-style-type: none"> 1. "Help Quit Kit" and "I Quit Kit"
American Cancer Society
90 Park Avenue
New York, NY 10016 2. "Helping Smokers Quit Kit" and "Calling it Quits"
Office of Cancer Communications
Building 31, Room 4B39
Bethesda, MD 20014 3. "Doctor, You Really Can Help Patients Quit Smoking"
American College of Chest Physicians
911 Busse Highway
Parkridge, IL 60608 | <ol style="list-style-type: none"> 4. "How To Help Your Hypertensive Patients Stop Smoking"
Office of Cancer Communications
Building 31, Room 4B39
Bethesda, MD 20014 5. "Smoking and Pregnancy Kit for Health Care Providers"
American Lung Association
1740 Broadway
New York, NY 10019 |
|--|---|

State-of-the-art self-help guides

- | | |
|---|---|
| <ol style="list-style-type: none"> 1. "Freedom From Smoking for You and Your Family" (1 Vol) or "Freedom from Smoking in 20 Days" and "A Lifetime of Freedom from Smoking" (2 Vols) or "In Control" (Videocassette and Viewers Guide)
American Lung Association
1740 Broadway
New York, NY 10019 2. "Fresh Start"
American Cancer Society
90 Park Avenue
New York, NY 10016 | <ol style="list-style-type: none"> 3. "Free and Clear"
Group Health Cooperative of Puget Sound
Center for Health Promotion
521 Wall Street
Seattle, WA 98121 4. "Understanding Yourself as a Smoker" (for precontemplators) and "Learning from Relapse" (for relapsers/recyclers)
Self-Change Program
420 Chafee Hall
University of Rhode Island
Kingston, RI 02881 |
|---|---|

quitting barriers. Contemplators and those in action stages who have not begun or completed their quitting plan should be encouraged to set a definite quit date. A future followup contact should be scheduled.

Smokers who quit but have relapsed should be helped to analyze the circumstances leading to the setback, and to make a new quitting plan which includes a way to deal with these circumstances in the future. Relapsers should be clued into the "abstinence violation effect"—whereby unnecessary guilt and self-blame after a slip actually can help pave the way to full-blown relapse.⁵⁰ "Well, now that I've slipped and smoked one cigarette, I've really blown it. I guess I just don't have what it takes to succeed. I may as well throw in the towel." Upbeat messages normalizing repeat quit attempts should be given and repeated. Re-cyclers should be encouraged to maintain any changes they have made—using deep breathing instead of smoking, getting more exercise, smoking fewer cigarettes, or a lower nicotine brand—and assisted to select a new quitting strategy and quit date (no matter how far off). De-

pending on the relapser's experience with the initial treatment, and analysis of factors contributing to the relapse, he can be advised to try the same approach again, or to switch to another approach. A definite followup contact should be scheduled. And, as before, it should be clear to the patient and to the physician that each attempt brings the smoker that much closer to permanent nonsmoking, and that different timing, and/or a new approach, may be all that is needed to succeed.

SUMMARY

This paper proposes a cyclical model for quit smoking treatments in primary care settings. Based on studies of physician intervention and research establishing quitting as a multistage process often involving repeated quit attempts, the model incorporates elements of triage and staging into a stepped-care approach that offers smokers more specialized or more intensive help as they progress through the various stages of smoking cessation or repeated quit attempts. ■

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Use in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to clordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for clordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, orthostatic heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of ureters.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestations and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly.

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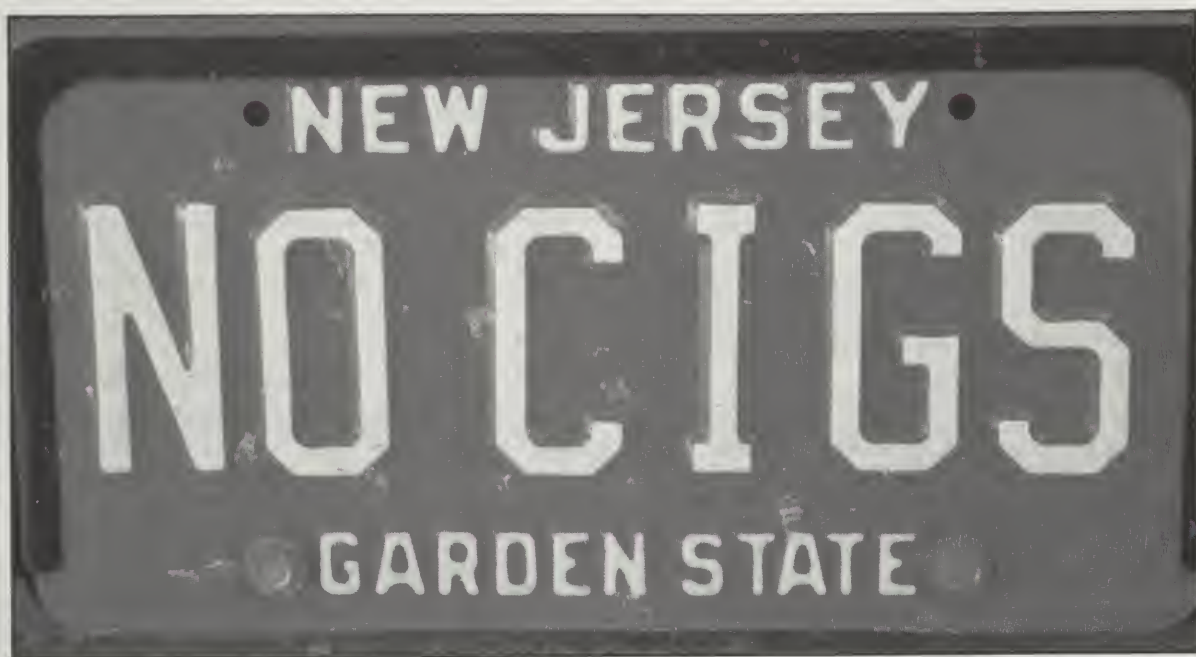
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Tobacco Dependence in Treating Alcoholism

GERALDINE O. DELANEY, LHD



The Little Hill-Alina Lodge Foundation Board was presented the facts available on addiction to tobacco by our Medical Vice-President, Thomas Fleming, MD, and voted 23 to 3 to stop smoking in our treatment center. The staff and students of this alcohol treatment center were given six months to consider this decision, and staff from the American Cancer Society gave lectures and exercises to help those staff members and residents who would be at the center when the no-smoking

policy would go into effect on March 1, 1985. To date, no staff members have left and only two residents have left, saying their reason for leaving was because they could not smoke. The evidence on these residents, however, implied that they were using smoking as the best excuse they could find; their drinking and drug-taking also returned immediately.

Before stopping the smoking at Little Hill-Alina Lodge, we began using decaffeinated coffee, taking sugar off the tables, and incorporating a salt substitute. We always have used a high-protein, low-carbohydrate menu with fresh vegetables, salads, fish, and chicken, along with skim milk, cheeses, and fresh fruit. When people begin to gain weight

Geraldine O. Delaney, LHD, is Chief Executive Officer, Little Hill Foundation. Reprint requests should be sent to Dr. Delaney, Little Hill Foundation, Blirstown, NJ 07825.

from eating too much, we put them on a weight watching diet.

FOLLOWUP

We have not done a formal survey because we wish for the first group to have had at least a year in the community before we survey their drinking, drug-taking, and smoking habits. On casual verbal survey, we find that the women have been having a more difficult time staying abstinent from tobacco than men. Recently, we have established a rule that they may not come back to the center after a therapeutic leave if they return to smoking since their clothes smell of smoke, offending the in-residence students, particularly the women.

What do we do to help the residents when they go home? The group therapy of Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Over-Eaters Anonymous, and Smokers Anonymous always are recommended and explained while they are in residence. We suggest that they go to non-smoking meetings, which are proliferating since more organizations, buildings, and churches are banning smoking on their premises. One recommendation we make as a helping hand is to encourage them to carry pen and notebook, so they will have something to do with their hands. They also can jot down notes that may be helpful to them along the way. We point out to them that in applying for a job, they may not be hired if they smoke, because the chance of illness among smokers is greater and many businesses are looking into this problem very closely.

We believe that it is not sound case management to allow an individual to recover from one fatal illness, alcoholism or drug addiction, while allowing them to progress into another. Cigarettes are every bit as lethal as alcohol and we need healthy role models, hence the insistence that our staff do not smoke. Smoking is not allowed on the grounds of the facility (60 acres) by students, families, visitors, staff, and delivery people. We cannot control what they do at home, but we insist that the staff not appear smelling of tobacco smoke. I believe treatment is assisted by an atmosphere free of any drugs, and we encourage the people to speak freely of their dual addictions, from alcohol to drugs, eating, or tobacco.

The key to recovery from any addiction is facing the truth and deciding what action to take. We give the students a list of some of the lethal chemicals in cigarettes, such as acetone, ammonia, DDT, formaldehyde, methane, phenol, as well as nicotine.

RULES FOR A TOBACCO-FREE LIFE

Recovery from tobacco dependence becomes quite simple, as it is with recovery from drinking and

drugging:

1. Lay the cigarette down and don't pick up Nicorettes® or a pipe.
2. Don't try it—not even one puff.
3. Don't keep cigarettes around the house.
4. Don't carry cigarettes in your mouth, saying that you are not really smoking.
5. Withdrawal symptoms will come, but remember, "This, too, shall pass."
6. At times, the head will tell you that you really don't need to stop—don't listen, for you know better.
7. If you always had a cup of coffee when you smoked, change your routine—a tall glass of water or another beverage. Drinking lots of liquid, especially water, helps.
8. Get friendly with people who do not smoke.
9. Do some deep breathing and regular exercises like stretching or isometrics.
10. Don't sit around after meals if this was a time when you smoked—keep active.
11. Don't sit in the same place you usually sit at meetings; locate the door and sit as far away from it as you can; the smoke will be drawn out the door.
12. Remember, you aren't quitting forever—just one minute, one hour, one day at a time.
13. Be grateful that you don't have lung disease.
14. Being grateful and thinking positive will help a great deal, and group therapy at AA and NA meetings is very helpful.
15. Go to a nonsmokers' organization if there is one around. Sit in no-smoking sections wherever you go. (Even the airlines have almost all their seats nonsmoking, and soon we're hoping for a smoke-free airline.) Remember, nonsmokers are in the majority.
16. Have your clothes cleaned so they don't smell of smoke and spray deodorants in your house and closets every time the odor raises its ugly head.
17. Be careful of secondhand smoke: two-thirds of the smoke from burning cigarettes goes into the environment. Side-stream smoke comes to you as well as smoking a cigarette yourself.

SUMMARY

Tobacco dependence is a common addiction among people who also suffer from alcoholism and other chemical dependencies. Although overlooked for many years, tobacco causes an enormous burden of illness in the people who present for the treatment of other addictions.

Tobacco dependence should be approached therapeutically in the same way as other addictions. The therapist must know the way, show the way, but also go the way, saying, "I can do it, so can you."

Little Hill-Alina Lodge became smoke-free nearly three years ago. The policy has been well accepted. Students are taught how to lead lives free of tobacco as well as other drugs. ■

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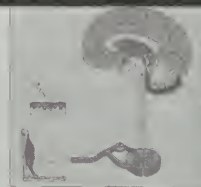
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PRACTICAL • CLINICAL • EDUCATIONAL • CURRENT

The Nurse's Role: Decreasing Tobacco Use

ELIZABETH W. WILSON, RN, EdD

*Nurses can act collectively and individually to promote a smoke-free society.
All nurses need to be positive role models as well as agents of change.
Other nursing activities involve identifying and modifying risk behavior
through education and support.*

The functions of the nurse clearly include the promotion of health and the prevention of disease.¹ For this reason, the profession must work collaboratively with other health professions to change the circumstances that promote the initiation and continuation of smoking.

To many nurses and physicians, the traditional role of caregiver is most comfortable. Yet it is not enough to provide compassionate and competent care for the victims of smoking diseases. Such a narrow focus ignores the preventable nature of these diseases.

A literature review by Rosen and Ashley examined role recognition and performance among health professionals concerning the issue of smoking and health. Five major roles were identified: exemplar, educator, identifier-modifier of risk behavior, lobbyist, and researcher.²

EXEMPLAR ROLE

For nurses and other health professionals, the role of exemplar generally is recognized, if not always accepted or welcomed. Once a member of the public identifies a person as a nurse, that nurse becomes either a positive or negative role model whose personal behavior is subject to scrutiny.

In the area of smoking behavior, what does the public see? The 1975 U.S. Department of Health, Education and Welfare study of health professionals reported that 38.9 percent of nurses, 28 percent of

pharmacists, 23 percent of dentists, and 21 percent of physicians were smokers.³ The 1978 to 1980 National Center for Health Statistics survey indicated that 28 percent of nurses and 18.1 percent of physicians were current smokers.⁴ The 1982 American Cancer Society's Cancer Prevention Study II showed that 23.4 percent of nurses, 16.7 percent of physicians, and 14.1 percent of dentists were current cigarette smokers.⁵ The same report adds that another 8 percent of both dentists and physicians smoke cigars or pipes, suggesting that the rate of tobacco dependence in each of these three groups is nearly identical.

A 1984 study of 1,719 registered and licensed practical nurses at a large urban teaching hospital determined that 22 percent of nurses were current smokers.⁶ There is, then, an encouraging implication in these surveys that the prevalence of smoking among nurses is declining.

Whether or not this is a response to increasing acceptance of the exemplar role or just part of a general trend toward smoking cessation is unknown. A correlational study of smokers, former smokers, and nonsmokers among nurses in Connecticut indicates that fewer nurses who smoke agree that nurses should set a good example, should not smoke while working, and should not smoke anywhere in public when in uniform.⁷ Nurses who never smoked demonstrated the greatest commitment to the role of exemplar.

Further decreasing the proportion of nurses who smoke will likely require innovative approaches. For example, a comprehensive effort to provide hospital nurses with worksite smoking cessation programs involving support networks and stress and weight management assistance is underway at the Univer-

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sity of California.⁸ Evaluation of the study is incomplete, but preliminary findings are promising.

EDUCATOR ROLE

Counseling and teaching are major nursing responsibilities. Nurses spend much time with patients and have a great opportunity to assist them in the goal of smoking cessation. A number of teachable moments occur in the clinical setting: prior to surgery, when every smoker should be told of the benefits of not smoking for at least 24 hours preoperatively, and when it is appropriate to encourage complete cessation; postmyocardial infarction, an introspective time when the nurse has a perfect opportunity to help the patient understand how he can help prevent recurrence; during diabetic counseling to help prevent sequelae; and when counseling cancer patients. Recent evidence suggests that nicotine promotes metastasis and that avoidance of it may improve the odds for survival.⁹

The independent role functions of the nurse include preparing nursing care plans based on assessment. When alterations in respiratory function, peripheral circulation, or blood pressure are related to smoking, a major intervention is to initiate health teaching directed toward assisting the patient to decrease or stop smoking and to find alternative adaptive coping mechanisms.¹⁰

In a 1985 report, the National Cancer Institute estimated that if only 10 percent of physicians incorporated simple smoking intervention techniques into their practices and if only 25 of their patients quit smoking, more than a million individuals could become former smokers each year.¹¹ If the 1.7 million nurses were to collaborate in this educational effort, the effect would be magnified enormously. For this reason, both physicians and nurses need to routinely ask about tobacco use when taking histories and then act appropriately. No patient should remain ignorant of the role tobacco plays in the development or progression of disease. Once educated about this, the patient may be open to further suggestions about smoking cessation.¹²

Increasing numbers of nurses are employed in settings outside of the hospital. Nurses in business, industry, schools, and health maintenance organizations can conduct informational programs, provide self-help materials, and set up mutual support groups for cessation using materials readily available from agencies such as the American Cancer Society, the American Lung Association, and the American Heart Association.

Nurses working outside of the hospital have the opportunity for long-term follow-up. Smoking status needs to be prominently indicated on the patient file. If there is a flag on the chart, the practitioner can be reminded, each time the person is seen, to

express an interest in the progress being made toward smoking cessation.

Nursing education programs need to include relevant data about smoking within their curricula and provide cessation support for students who smoke. Recent nursing textbooks emphasize the nurse's responsibility to be aware of the most recent anti-smoking programs, to be active in these programs, and to interpret them to the public.¹³

Observance of the current New Jersey law which restricts smoking in health care facilities (C319-1 26:3D-7 et seq.) or the successful implementation of a completely smoke-free policy by a hospital depend to a large degree on the commitment of nurses. Any proposal to eliminate smoking in a hospital will necessarily involve the participation of nurses in both planning and implementation.

IDENTIFIER-MODIFIER ROLE

Few people seem to understand the enormous risks of smoking. The public needs to understand three interrelated facts: 1) the magnitude of the risk from smoking; 2) the individual's probability of dying from smoking-induced diseases; and 3) the risk of dying from smoking, relative to that from other causes of death.¹⁴ For example, although many believe that motor vehicle accidents are a greater risk than smoking as a cause of death, the chance of a 35-year-old man dying of such an accident before age 65 is 0.7 percent and before age 85 is 1.0 percent. Yet a heavy smoker has a risk of dying from smoking that is 16 percent by age 65 and 36 percent by age 85.¹⁴

In order to overcome the effects of regular media reports about hazards of far less significance, smokers need to know how tobacco affects them personally. Smokers overlook the fact that cilia are being damaged every day by hydrogen cyanide in inhaled cigarette smoke. Nurses need to identify smokers as individuals with exceptionally high risk for disease and attempt to modify that risk. A pregnant woman needs to know that the oxygen supply of her baby is being compromised. A patient who is reluctant to have an appropriate x-ray needs to know that cigarettes cause daily exposure to radiation. A person concerned about the additives used to preserve food should be educated about the chemicals used in growing and processing tobacco.

It is important to understand that nicotine is an addictive drug.¹⁵ Because nicotine is addictive, strategies for intervention need to be designed with recognition of the dependency factor. Reluctance to intervene with smokers in managing tobacco dependence may be related to a lack of preparation for this role. Continuing education programs can assist nurses and others to use the resources that already are available. Research programs are providing ad-

ditional information about optimal ways of supporting smokers in their efforts at cessation.

LOBBYIST ROLE

As individuals and as members of professional associations, nurses can be effective lobbyists for decisive action to control smoking. Representatives of the New Jersey State Nurses' Association (NJSNA) helped lobby for the passage of the New Jersey clean air laws and the NJSNA is committed to working for further legislation. In 1984, NJSNA submitted five resolutions which were adopted by the American Nurses' Association; the adoption of the resolutions represents a national commitment by nurses to reduce smoking among nurses, to involve nurses in research on smoking behavior, to educate nurses to the hazards of smoking, and to influence public policy to accelerate the decline of smoking.¹⁶

Nurses can lobby individually in a very effective way by insisting that clean air policies be implemented in local school, community, and workplace settings.

RESEARCHER ROLE

Nurses should assume a greater role in research. Funding is available from the National Center for Nursing Research at the National Institutes of Health for nurses who are prepared to submit grants for work in health promotion and other areas. Vital areas of research for nurses include: smoking behavior in nurses; coping mechanisms of nurses; effectiveness of cessation programs for nurses; survey of nursing education for content related to the risks of smoking; and the effectiveness of interventions in assisting patients to stop smoking.

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Informal research opportunities are available as well. An oncology unit staff, for example, may keep a record of all admissions to see what percentage of patients are or were smokers; or a hospital nurse may conduct research on the smoking policy in the hospital and how it is working.

The participation of nurses in active research would be facilitated by a PhD in nursing program in New Jersey. Undergraduate and Master's programs in nursing now are placing greater emphasis on research. Presently, fewer than 100 New Jersey nurses have doctorates.¹⁷ There is a need for nurses who are better prepared to carry out research.

SUMMARY

Nurses are a valuable resource in the effort to reduce the prevalence of tobacco dependence. Administrators, public health planners, and policy makers should be encouraged to engage the support of nurses for public education, cessation strategies, and actions to promote smoke-free environments.

Studies have shown that most nurses do not smoke and therefore are performing the exemplar role. Those who continue to smoke should receive assistance at the worksite. More research is needed to determine the most effective strategies for assisting nurses to manage tobacco dependence.

Hospital nurses spend more time with patients than any other health professionals. For this reason, nurses should be in a position to identify patients at risk of health consequences from tobacco dependence, and they should be able to intervene appropriately. Community nurses can help lobby in the effort to work towards a smoke-free society. ■

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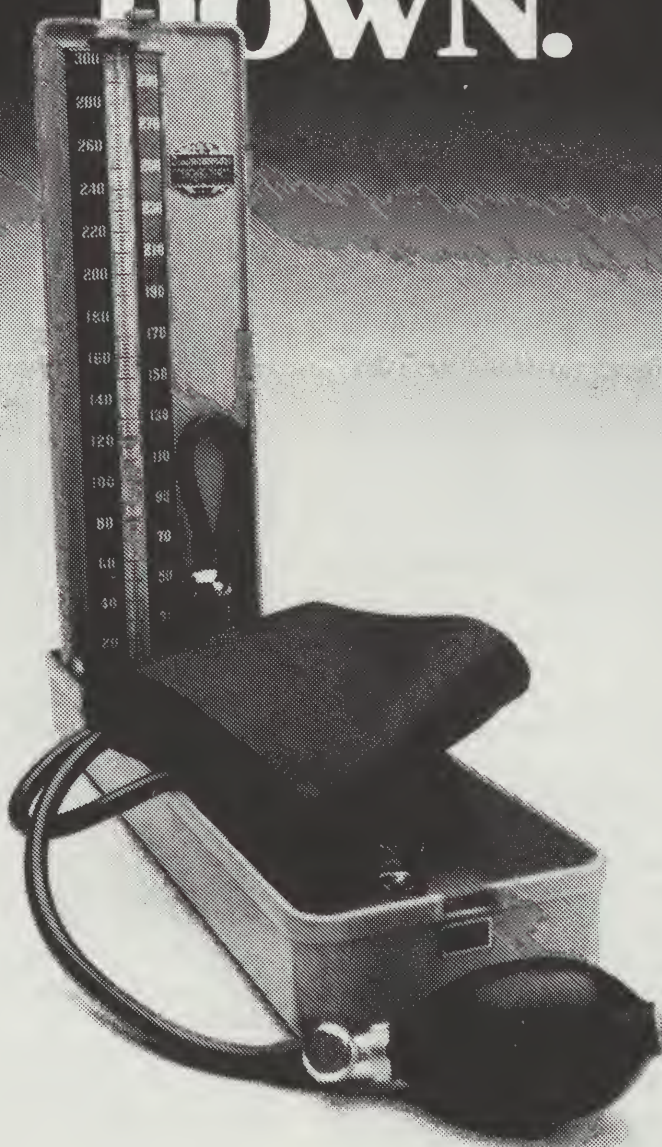
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Clean Air At Work: It Makes Sense

REGINA CARLSON



This unusual message is printed in 11 languages by Ecusta, a major manufacturer of cigarette paper.

Clean indoor air policies in the workplace are a potent part of creating a cultural environment that supports nonsmoking and health instead of addiction and disease. There are several reasons for this: most people spend many of their waking hours at work; employers have authority to set behavioral standards which employees must

meet; and workplace standards influence standards in other sites.

Yet, employers have been hesitant to create clean indoor air policies in their workplaces. There are several possible explanations: society has allowed smoking considerable social respectability; cigarettes are one of our most heavily advertised products and the tobacco industry is a powerful political force; and smoking is an addiction that is difficult to deal with in a sensible manner.

To help decision makers overcome trepidation about creating nonsmoking policies, here are some perspectives and solutions:

1. It always is difficult to look objectively at some-

Ms. Regina Carlson is the Executive Director of the New Jersey Group Against Smoking Pollution (GASP). Requests for reprints should be sent to Ms. Regina Carlson, New Jersey Group Against Smoking Pollution, 105 Mountain Avenue, Summit, NJ 07901.

thing that is part of the status quo. Imagine this scenario: A representative of X Cigarette Company comes to your workplace saying, "We'd like to market our product in your company. It comes in these snazzy packets with pretty red letters and foil wrappers. We will supply machines to dispense the product conveniently to your employees at work. Of course, one-third of your employees who use our product will get heart disease and one-tenth of the users will suffer lung cancer, a disease that is rare in the absence of our product. Users will be absent twice as frequently as nonusers. Employees using our product also will make nonusers ill and will anger them. Nonusing employees may sue you for protection from our product. Byproducts will damage delicate electronic equipment in your company. You will have higher fire insurance. There will be increased ventilation problems. Carpets will be burned." What employer would buy that bill of goods?

2. Asking people to limit smoking at work is normal outside office workplaces. School teachers, nurses, bank tellers, retail clerks, and assembly line workers (including those who operate machinery making cigarettes) smoke only on their breaks.

3. Evaluate tobacco smoke in your workplace as compared to other standards applied to other substances in the workplace. We do not know what is in cigarette smoke. Cigarettes have been excluded from laws requiring disclosure of ingredients. John Banzhaf, Executive Director of Action on Smoking and Health, said, "I could go out tomorrow and manufacture a cigarette made of tobacco, saccharin, arsenic, and horse manure, and I'd be subject to almost no government regulation." Of course, we do know many of the constituents of cigarettes and tobacco smoke. Nicotine and carbon monoxide usually come to mind. The American Lung Association reports that an office worker sitting next to a two-pack-a-day smoker is exposed to carbon monoxide levels twice as high as allowed by the Occupational Safety and Health Administration (OSHA) in industrial settings. Ammonia and hydrogen cyanide are present in tobacco smoke. By standards of protection from occupation hazards, cigarettes have no place in the workplace.

4. Compare how employers respond to other health problems and other drug addictions that may affect their employees. They offer withdrawal programs, education, testing, inoculation, and incen-

tives. Kenneth Warner, chairman of the Department of Public Health Policy of the University of Michigan School of Public Health quantifies smoking's impact dramatically: smoking kills more Americans than alcohol, heroin, cocaine, suicide, homicide, auto accidents, fires, and AIDS combined. Companies without clean air policies are encouraging smoking.

5. Industrial workplaces are controlled by environmental pollution laws. Why is indoor air pollution in office workplaces treated so differently? As a member of New Jersey GASP said, testifying

before a New Jersey Assembly committee, "It's illegal to burn leaves outdoors. How come people are burning leaves indoors where I work?"

6. Jacquelyn Rogers, the New Jersey woman who founded Smokers, recognizes that smoking certainly is compulsive but she points out that breathing is involuntary. A smoker can choose to be-

come a nonsmoker, can postpone a smoke, can refrain from smoking, or can step outside. A nonsmoker cannot choose to refrain from breathing eight hours a day at work.

7. Consider special facilities for handicapped workers, i.e. ramps and wheelchair-accessible toilets. What environment are you providing for employees handicapped by asthma or heart disease, or for healthy nonsmokers, who probably comprise the majority of your workforce, those who prefer unpolluted air?

8. A useful parallel exists in the process of change our society is pursuing about alcohol. Alcohol and tobacco are our most destructive drugs of dependence because they are our legal and popular drugs. We are recognizing that alcohol is more destructive than we thought and we are working to protect nonusers—by raising the age for drinking and increasing penalties for drunken driving. Employers are offering more programs for addicted employees and ending the use of alcohol at company parties. People are being told to say "no" to friends who want to drive drunk and to be sure to provide nonalcoholic drinks at parties.

We are recognizing that tobacco's toll is much greater than we had thought. We are stepping up efforts to ensure that children remain nonusers and we are protecting nonsmokers with clean indoor air laws. Companies are creating policies. People are putting up signs saying "Welcome to our smoke-free home" and removing ashtrays from their homes. ■



Scientific Basis for Workplace Clean Air

LAWRENCE A. MEINERT, MD, MPH



Smoking is New Jersey's most important cause of preventable disease and premature death. Nearly 11,000 deaths each year occur in individuals as a result of their smoking.¹ In New Jersey alone, smoking produces annual economic losses of nearly \$790 million from increased health care costs and another \$1.3 billion in lost wages and productivity due to illness. These estimates are based upon applying national attributable risk functions on New Jersey mortality and cigarette sales data: cancer deaths, 32 percent; cardiovascular disease deaths, 13 percent; chronic obstructive lung disease deaths, 88 percent; health care costs, \$0.72 per pack; lost productivity, \$1.45 per pack.

DANGER FROM OCCUPATIONAL EXPOSURE

A growing body of evidence indicates that involuntary exposure to tobacco smoke poses a substantial health hazard to nonsmokers. This comes as no surprise to physicians who have witnessed the deadly consequences of tobacco in generations of patients. The main features of the evidence for this are summarized below, following the line of argument of a petition presented in 1987 by Public Citizen Health Research Group and the American Public Health Association to the Occupational Safety and Health Administration which seeks to prohibit smoking in indoor workplaces.

A. Toxic and Carcinogenic Chemicals in Environmental Tobacco Smoke. Several thousand individual compounds have been identified in tobacco smoke. Nonsmokers are exposed primarily to unfiltered side stream smoke, which enters the air directly from the burning end of a cigarette. Since

the combustion temperature is lower when a cigarette is smoldering, side stream smoke actually contains higher concentrations of many of these harmful substances than does mainstream smoke. Carbon monoxide, benzene, toluene, n-nitrosamines, and nicotine are just a few of the compounds found in side stream smoke.²

B. Worker Exposure. Nonsmokers absorb and metabolize smoke constituents just as smokers do, albeit at lower levels. Metabolic products unique to cigarette smoke have been detected in the blood, urine, and saliva of nonsmokers after exposure to environmental tobacco smoke. Although levels vary, the typical office exposure of a nonsmoker to environmental smoke is equivalent to between one-sixth and one-and-a-half cigarettes per day.²

C. Health Effects of Worker Exposure. Numerous studies have documented a dose-response relationship between the number of cigarettes smoked and lung cancer, heart disease, and other diseases. These dose-response relationships suggests that lower levels of exposure such as those experienced by nonsmokers in an office where smoking is allowed are likely to pose a hazard. Studies of passive smoking indicate that the exposure of nonsmokers to environmental tobacco smoke increases the risk of lung cancer by 25 percent over that of individuals who live in smoke-free environments.³ Losses in lung function similar to those of light smokers have been documented in nonsmokers exposed to smoke-filled environments.⁴ Acute decrements in pulmonary function of asthmatics may occur in a smoke-filled environment. Increased heart disease has been observed in nonsmoking women married to smokers;⁵ risk of heart disease was triple over that observed in the control group. A comparable risk may exist for nonsmoking employees exposed at work. Individuals with pre-existing heart disease may experience angina at lower levels of exercise in a smoke-filled environment. Two studies indicate that nonsmoking pregnant women exposed to environmental tobacco smoke for at least two hours a day have nearly twice the risk of delivering a low birth weight baby.^{6,7} Ir-

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ritation of the eyes and nose is a symptom reported by two-thirds of nonsmokers exposed to environmental tobacco smoke.⁸

VENTILATION ISSUES

The actual composition and concentration of environmental tobacco smoke in an enclosed space will depend on a variety of factors, including: the number of cigarettes smoked and the rate at which they are smoked, the type of cigarettes, the size of the room, and the rate air is exchanged by the ventilation system.

However, lighted tobacco products clearly are not the only source of indoor air pollutants. Insulation, carpeting, and photocopy machines can give off a variety of fumes. Increased ventilation with fresh outside air is necessary to reduce exposure to all types of pollutants in an indoor environment regardless of the source.

Increased ventilation will reduce, but not eliminate, environmental smoke exposure. Tobacco smoke is mostly gases which quickly equilibrate throughout an enclosed work space. Even in a private office—unless it is negatively pressurized relative to the adjacent areas—tobacco smoke will escape over or under doors or through open doors. Heavy, aerosolized particulate matter will tend to remain concentrated in a private office. If there is an air intake in that room, however, smoke will be recirculated throughout the building. The only way to eliminate environmental tobacco smoke exposure is to eliminate tobacco smoke from the building's air handling system.^{2,8}

NJ WORKPLACE CLEAN AIR LAW

The accumulating evidence of harm from and changing social attitudes towards ambient tobacco smoke led to the passage in 1985 of NJSA 26:3D-23 et seq. (PL 1985, Chapter 184) which controls smoking in private places of employment.

This law articulates the principle that the right of the nonsmoker to breathe clean air supersedes the right of a smoker to smoke. Private employers with more than 50 employees in a given building are obligated to have a written policy which protects the

health, welfare, and comfort of employees. The law, as currently written, gives employers great latitude in determining what this means in developing their own policies. Unfortunately, some employers have taken a minimalistic view of the law. For instance, some have designated bathrooms as the only non-smoking areas.

Based upon the available evidence of the potentially harmful effects of tobacco smoke, the Health Department has issued a guideline to assist employers as they develop clean air policies for their businesses. The guideline states that where employees spend the majority of their work day should be completely free of tobacco smoke. Smoking-permitted areas are optional, and such areas should be in locations which are not part of the main air handling system. Nothing in the law prohibits an entirely smoke-free workplace. In fact, this often is a popular solution to the problem that the New Jersey State Department of Health and the Medical Society of New Jersey have implemented.

A petition presently before the Federal Occupational Health and Safety Administration seeks to create smoke-free workplaces wherever OSHA has jurisdiction. Such regulation would extend worker protection further than present New Jersey law. As experience with workplace clean air policies accumulates, information is becoming available which will help determine if the New Jersey workplace clean air law should be strengthened to further improve the public health.

SUMMARY

Environmental tobacco smoke contains thousands of compounds, many of which are known to be toxic. Nonsmokers exposed to ambient tobacco smoke absorb measurable levels of smoke constituents. Increased risks of lung cancer, pulmonary dysfunction, heart disease, and low birthweight infants have been associated with the exposure of nonsmokers to ambient tobacco smoke. Complete protection of workers from tobacco smoke in indoor workplaces is only possible if smoking is not permitted except in places with completely separate ventilation systems. ■

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The Smoke-Free Hospital

JEFFREY BURTAINE, MD, and JOHN SLADE, MD



Over the past ten years, hospitals throughout the country stopped selling cigarettes; sales seemed inconsistent with the missions of caring for the sick and preventing illness. Since 1983, a growing number of health care facilities have implemented policies to become free of tobacco smoke as well. These policies have been motivated by the evidence that tobacco smoke is both an irritant and a hazardous substance in the environment,^{1,2} by the realization that clean air policies can help set the tone for smoking treatment and prevention efforts, and by the fact that individuals who want to stop smoking may be better able to accomplish this if their environment provides them with opportunities to practice not smoking.

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A large experience in industrial settings has demonstrated the popularity of complete bans on smoking in the workplace.^{3,4} It now is clear that clean air policies can be popular in hospitals as well.

In this report, we outline the steps taken to implement a policy in two Pennsylvania hospitals which nearly eliminated smoking; we also review some of the developing information on the experience in other hospitals which have instituted even more complete bans on smoking.

STEPS TO THE CLEAN-AIR POLICY

The Allentown Hospital is a 337-bed community hospital specializing in psychiatry, obstetrics-gynecology, pediatrics, internal medicine, and surgery. Lehigh Valley Hospital Center is a 482-bed acute care hospital, featuring a trauma unit, burn center, and cardiac surgery facilities as well as large general surgery and internal medicine services. The hospitals are part of a multihospital system known as HealthEast. The hospitals implemented the no-smoking policy in April 1986. However, the develop-

ment process began a year earlier. The sequence of events is as follows:

1. The Chief Executive Officer (CEO) approved the policy after presentation of: A) Economic aspects—a smoking employee costs the employer between \$500 and \$1500 more per year than a nonsmoking employee. A person who smokes experiences increased absenteeism, uses more short- and long-term disability, uses more health insurance benefits, and causes more damage to the physical plant itself. B) Leadership—the hospitals should be in a leadership position for health promotion in the community. C) A no-smoking policy was the right thing to do—as smoking is the number one cause of death and disability in the western world.

2. A presentation then was made to the hospitals' management teams to obtain their support.

3. Reports were given at meetings of each major medical and surgical department.

4. Once the various departments had given their approval, the specifics were presented to the Medical Executive Committee. At the Executive Committee meeting, a respected physician voiced what he called the "freedom issue." He suggested that smoking was a matter of personal freedom, and that the next thing to be proposed would be restrictions on overweight people. In the ensuing discussion, it was pointed out that smoking in hospitals is not a simple "freedom issue," because tobacco smoke is a health hazard for all who are exposed to it. Thus, it is quite different from obesity, because an individual's weight is not a health hazard to anyone else.* After debate, the proposal was approved without dissent.

5. A presentation was made before the Employee Relations Panel to start introducing the concept of the smoke-free hospital to employees. The Panel members, smokers, and nonsmokers were very supportive of this concept.

6. A survey of all employees was conducted. Only 22 percent smoked, and half of these indicated that they wanted to quit smoking. A third of all employees favored a complete ban on smoking in the hospitals, a third of the employees preferred smoking in only one area, and a third of the employees wanted smoking to be allowed everywhere.

7. The proposed policy then was presented to the Board of Trustees for approval. The Board gave its approval after reviewing the survey results and hearing of the support the proposal had among the CEO, the managers, the medical staff, and the Employee Relations Panel.

The policy established the hospitals as smoke-free

with two exceptions: one tiny smoking lounge, behind closed doors, would be retained in each hospital for the use of employees and visitors, and inpatients would be permitted to smoke on the written order of their attending physician. The policy indicated that the medical staff should write such orders only if smoking was "necessary" for the "physical or emotional well being of the patient."

8. The policy was presented to department heads, to the department of nursing, and to all employees with an implementation date of April 1, 1986.

9. The program for employees included five elements:

A. All employees who quit smoking would be paid \$100 after they had been abstinent for six weeks. This would be monitored by an honor system based on peer pressure. The employees who received \$100 would have their names posted on a bulletin board in the main lobby and also in the department where they worked. Employees who slipped and returned to smoking could be identified by their co-workers and reported. This happened in two cases.

B. Free stop-smoking courses would be offered to employees and their significant others for 12 months. Both hypnosis and behavior modification were provided.

C. Health counselors would meet with any employee who felt in need of assistance. The health counselor would be available for helping with smoking cessation and with stress management. In addition, the counselor could arrange for the employee to receive a prescription for nicotine gum as needed through the employee health service.

D. No special disciplinary policy was formulated in regards to smoking by employees.

E. To reward nonsmokers, two lotteries for this group were held: in October 1985 and in April 1986. Thousands of dollars in savings bonds were given out as prizes to those who did not smoke.

10. The patient policy was that patients could smoke only on the order of their attending physician. This exception is subject to audit to insure that it is not abused. The admitting office has been instructed to tell patients that the hospitals are non-smoking institutions.

After more than a year, the policy is an exceedingly popular one. Among 4,200 employees, 211 people have quit smoking. This is just under a fourth of those who reported smoking in the initial survey. The smoke-free date, April 1, 1986, came and went without a problem. To date, there has not been one protest or one problem.

DISCUSSION

Clean air can become a reality for most, if not all, hospitals. Clear leadership, thoughtful preparation,

*Among inpatients, obesity often is treated as a medical matter. The diet is under the very specific direction and control of the attending physician.

and caring implementation are key elements for success. In these two hospitals, money, time, and effort expended implementing this policy have been more than justified by the positive results among employees and by the favorable response from the community.

There is a growing national experience with clean air policies in hospitals around the country. Among the first was the policy at Group Health Cooperative of Puget Sound, fully implemented in April 1984, which banned all smoking except for inpatients with a physician's order.⁵ Between 1983 and 1987, nearly the entire Indian Health Service has become completely smoke-free.⁶ An unusual program of technical assistance provided by the University of Minnesota with funding from the state health department has facilitated several dozen hospitals and nursing homes in Minnesota becoming completely smoke-free over the past two years.⁷ The Minnesota program demonstrated so convincingly the feasibility of "clean air health care" that a law was enacted in 1987 requiring all hospitals in that state to be smoke-free by 1990.

The Minnesota law summarizes what may be the practical extent to which clean air policies can be generalized to all health care facilities at this time. The law prohibits all smoking by staff and visitors. There are three optional exceptions for patients, however. Hospitals may elect to permit smoking by patients on written order of the attending physician, and chemical dependency units and mental health units may elect to set aside "a separated well-ventilated area pursuant to a policy established by the administrator of the program that identifies circumstances in which prohibiting smoking would interfere with the treatment of persons recovering from chemical dependency or mental illness." There are no other exceptions.

The Mayo Clinic has chosen to permit smoking by an inpatient only if there is agreement among the patient's physicians and nurses, and if the smoking consultation service concurs.⁸

Policies such as these are popular with patients

and staff. Kottke has reported that almost 90 percent of patients in the University of Minnesota Hospitals supported the establishment of a smoke-free hospital.⁹ Leibowitz could find no patient or visitor at the Beth Israel Medical Center in New York who thought a smoke-free medical center was a bad idea.¹⁰ Beth Israel became smoke-free on May 7, 1987. Most hospital staff, including nurses, do not smoke, and many, if not most, who smoke want to quit.¹¹ Among a wide variety of employee groups, clean air policies have been popular with both smokers and nonsmokers.^{3,4}

State medical societies are beginning to encourage hospitals and state health departments to act on this issue. The Arizona Medical Association passed a resolution in 1985 encouraging hospitals to ban smoking. In 1986, the Medical Society of New Jersey (MSNJ) called for legislation to eliminate smoking in acute care hospitals. In 1987, in cooperation with the New Jersey Group Against Smoking Pollution, MSNJ petitioned the Commissioner of Health to ban smoking in hospitals.¹²

The smoke-free hospital still is novel, but this is not likely to remain the situation for long. The logic for eliminating tobacco smoke from health care facilities is too compelling, and the positive experience with clean air policies to date amply demonstrates the practicality of this approach. Hospitals should protect the nonsmoker by providing clean air, and hospitals should help those who smoke by providing an environment which supports the only medically appropriate approach to tobacco use: abstinence.

SUMMARY

Complete or nearly complete bans on smoking have been implemented in a wide variety of hospital settings since 1983. These policies have been popular and successful. The logic of these policies is compelling, and interest in them is growing. Smoke-free hospitals provide an appropriate setting for caring for the sick, for counseling those who smoke or who are at risk of smoking, and for protecting the health of all. ■

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The Joy of Smoking

BONNIE VIERTHALER



During a conversation in a smoke-filled restaurant in the spring of 1986, I was suddenly awakened to the incredible discrepancy between the images in cigarette advertisements and what actually happens when a person smokes. I was outraged to think that somebody would deliberately manufacture a lethal product and then spend millions of dollars deluding people into buying it. "Somebody needs to make the ads honest," I said. My companion asked, "So what are you doing that's more important?" And that's how it all began for "The Joy of Smoking."

It was not easy. Several false starts and several months later, I hit upon a visual format which worked. By using actual cigarette ads from popular magazines and superimposing more honest images from medical journals, I was able to show the illness, death, and social consequences which result from smoking. Once I had the format, it took off like wild fire. The first 40 collages came together in about a month.

While the project began as a sort of practical joke, appealing to the mischievous side of my sense of humor, reactions by the first few viewers suggested that I had created a powerful statement, something which might make a difference. This process was a

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little like giving birth to a child in that the joy of creation ultimately gave way to responsibility. I brought these collages into being. Now my task was to usher them out into the world, to see that they reached the young people. This has become an ongoing mission: to dispel the powerful illusions of glamour conveyed by the tobacco companies and to replace them with more realistic attitudes about smoking.

ON THE ROAD WITH THE SHOW

Fulfilling this mission led to a somewhat frenetic year of traveling to schools, hospitals, health conferences, medical society meetings, shopping malls, and the Rotunda of the Russell Senate Office Building in Washington, D. C. It has been an eye-opening year. Young people candidly shared their poignant concerns about how tobacco was affecting their lives. I heard doctors, health educators, and antismoking activists describe the medical, health, and social issues related to smoking and point out the dubious business practices of the tobacco industry.

Getting the smoking exhibit to young people has been a roller coaster ride. High hopes repeatedly have plunged into disappointment as potentially supportive organizations went from elated, enthusiastic support for the exhibit to limp and embarrassed justifications about why they could not get involved. Some of our nation's largest health organizations fear the power of the tobacco industry. The actual support for my work has come from a few

dedicated individuals and grassroots organizations who understand the importance of reaching the children and who are willing to take a stand.

REFLECTIONS ON A YEAR OF TRAVELING

Back home on Deer Isle for the summer, I was blessed with the opportunity to assimilate and assess the events of the year. The collages and the exhibit have obviously been very well received. My overwhelming impression is that they have filled an important need.

Doctors, teachers, and health care professionals continually express to me their frustration with traditional smoking and health programs. They have told me, despite the variety of antismoking programs available, young people continue to be seduced by cigarette advertisements. "The Joy of Smoking" has been a breath of fresh air for them.

Young people love the exhibit because it focuses on something they are attuned to: advertising! The exhibit is both funny and gross, and it takes pot shots at the establishment—all the things they love to do. By graphically revealing the absurdity of the tobacco ads, the exhibit builds on and gives meaning to what young people already know. They get the message without cumbersome facts and statistics. Furthermore, it dares to do something many have secretly wanted to do themselves: it uses the tobacco companies' own ads to show the truth about smoking. It turns the ads against themselves.

Facts alone are not enough to influence the behavior of young people. While we might change their minds, we also must change their attitudes. My sense is that people usually make decisions on the emotional level and then use their intellects to justify these decisions. The cigarette ads are effective because their visual images implant subconscious concepts in the mind which equate smoking with happy, healthy, economically secure, but adventurous lifestyles. The ads appeal to the emotions by suggesting that these products will satisfy feelings of emptiness, inadequacy, and loneliness. And

they get results! On the other hand, programs which merely dispense facts work on the intellect. They're interesting and informative, but they don't change behavior because they don't impact the emotions. We need to tell the truth about smoking with equally powerful, honest images.

My year of travel with "The Joy of Smoking" has borne out this theory. The juxtaposition of images is proving to be an effective "right-brain" approach to a problem which has not been solved by "left-brain" educational methods. The exhibit works directly through the emotions, in the same way that the original ads do. It fights fire with fire.

I am finding that when young people see the power and hypocrisy of the tobacco ads, they are better able to understand that we are not subsidizing, selling, and smoking cigarettes because it is right, but because our society is consumed by the profit motive. They can see that we have all been victims of a very large mistake, one which can and must change. Moreover, by exposing the truth about cigarette ads, the exhibit puts young people in a position of control. They've caught the tobacco companies in a lie, and that puts them "one-up" on one of the most powerful industries in the country.

SUMMARY

"The Joy of Smoking" is a collection of 67 collages which parody cigarette and smokeless tobacco advertisements. It is designed to undermine the seductive imagery used by tobacco companies in recruiting new users. The emotional appeal of these counter-advertising messages lets the dry truths about smoking and health become genuine knowledge in powerful ways.

The exhibit has been shown in a wide variety of school, community, and professional settings. The reactions from young people and health professionals alike have confirmed the value of this approach in preventing teenage addiction to tobacco. For those interested, the exhibit is available for showings in 1988. ■

NJ State Commission on Smoking or Health

LEE B. REICHMAN, MD, MPH

The New Jersey Commission on Smoking or Health is an innovative partnership between the public and private sectors whose initial report provides a blueprint for attacking the problem of smoking and youth. The Commission is ready to help New Jersey focus on the problems caused by tobacco.

In 1986, New Jersey's then Commissioner of Health, Richard Goldstein, established the Commission on Smoking or Health to serve as an advisory board to the State Department of Health on matters concerning tobacco use and control. It was charged with the development of policy recommendations, suggestions for legislative action, and educational initiatives in this area. Mrs. Thomas H. Kean has served graciously as honorary chairperson of the Commission.

Among the specific topics posed to the Commission in its charge were: to review and evaluate the impact of existing state and local legislation regarding smoking and tobacco use on health; to review and recommend legislative action on clove cigarettes, vending machines, and the advertising of tobacco products; to evaluate the feasibility of differential insurance rates for tobacco users and non-users; to report on the economic impact of tobacco control in terms of health care costs and injury prevention measures such as self-extinguishing cigarettes; and to recommend educational and intervention programs for specific target populations.

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At the suggestion of Commissioner of Health Molly Joel Coye, the Commission has focused on tobacco and children as the subject of its first report. A public forum on children, teenagers, and tobacco was held in Trenton on November 19, 1986. At the forum, the Commission heard from more than two dozen citizens concerned about this problem. The Commission has prepared a report based on this forum and its subsequent discussions which outlines a program for preventing tobacco dependence in New Jersey's young.

New Jersey is a state whose government and citizens are extremely health conscious. Occasionally, in the zeal to solve the great health problems of the day, perspective about the relative riskiness of various hazards is lost. Thus, problems which may be more tractable politically, such as the abatement of asbestos in public school buildings, are addressed in a comprehensive manner while programs which would be less expensive but more beneficial for the public health, such as the elimination of smoking in all public places in New Jersey, receive less thorough treatment.

The Commission's task is to help New Jersey focus on the prevention of the multitude of problems caused by tobacco.

Tobacco is the leading cause of unnecessary illness and death in our state, and there is much which can be done to bring the tobacco-disease epidemic under control. ■



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Preventing Tobacco Dependence

THE NEW JERSEY COMMISSION ON SMOKING OR HEALTH

Smoking and other forms of tobacco use are the leading causes of preventable illness and death in New Jersey. Over 11,000 of our fellow citizens die each year as a result of diseases caused by smoking. Thousands of others endure the slow agony of illnesses produced by smoking such as emphysema and heart disease. The economic toll of tobacco use in the form of lost productivity and increased health care costs amounts to more than \$2 billion each year in New Jersey.

The magnitude of this public health problem should call us to action. We must move forward in a collective effort to reduce and prevent unnecessary illness due to smoking. The challenge is great, and our response will have to overcome 300 years of cultural and economic dependency on tobacco.

In recognition of the complexity of the issues that surround all attempts to eliminate tobacco related illnesses, an advisory Commission on Smoking or Health was appointed in February 1986. This Commission is comprised of outstanding leaders from many walks of life in New Jersey. They have spent the past year examining ways that we can prevent childhood and adolescent tobacco dependency.

The Commission's report provides a series of recommendations based upon evidence of the potentially harmful effects of tobacco smoke and patterns of tobacco use and addiction in the United States. It is our hope that further debate and public policy change will be stimulated as a result of the Commission's findings.

The Commission has given many hours to the development of this report, and the Department would like to express their respect and gratitude for the Commission's efforts.

*Molly Joel Coye, MD, MPH
State Commissioner of Health*

Tobacco is the leading cause of avoidable illness and death in New Jersey. Every year nearly 11,000 deaths are caused by cigarette smoking.

FINDINGS

1. Magnitude of the public health problem:

(a) Thirteen percent of cardiovascular disease deaths (4,300) are attributable to smoking cigarettes.

(b) Thirty-two percent of cancer deaths (5,000) are caused by smoking cigarettes.

(c) Eighty-eight percent of chronic lung disease deaths (1,600) are caused by smoking cigarettes.¹

The annual economic impact of tobacco on New Jersey is immense^{1,19}:

a. An estimated \$1 billion are spent each year to purchase over 880 million packages of cigarettes in New Jersey.

b. An estimated \$790 million are spent each year as the result of increased health care costs created by tobacco use in New Jersey.

c. An estimated \$1.3 billion are lost each year to the New Jersey economy by decreased productivity and earnings due to illnesses caused by tobacco.

Tobacco use has declined among all age groups except children.² A 1986 high school survey of 10th, 11th, and 12th grade students in New Jersey indicates that almost 40 percent smoke; half smoke every day. These data are unchanged from 1980.

Although data are incomplete, it appears that smoking prevalence among those who drop out of school is higher than it is for those who remain in school. The reported prevalence figure of 40 percent for high school students probably underestimates the size of the problem.

In New Jersey, about 50 percent of teenagers who become pregnant smoke.³ The effects of cigarette



smoking may account for 25 percent of the low birth weight deliveries in this group.⁴

Nicotine produces a chemical dependence (addiction) in exactly the same sense that other drugs, such as heroin, cocaine, and alcohol, are dependence-producing.⁵ About seven out of ten people who use tobacco regularly are addicted to it. Most smokers start smoking as children. Studies indicate that the younger one starts to smoke, the harder it is to quit. When smoking is started at a younger age, many of the diseases produced by smoking are manifested at a younger age. The younger one starts, the more likely one will become ill from smoking.

2. Lack of public awareness and understanding of smoking issues:

The present public concern about the use of alcohol and other drugs by children has not included tobacco. There is a lack of awareness that tobacco is an addictive substance. While most adults and children believe that cigarettes are harmful, the public underestimates the enormous magnitude of that harm.

3. Extensive cultural and social influences encourage children to smoke:

Although tobacco companies claim their advertisements are not directed at children, the themes employed in their \$2 billion annual marketing effort are clearly appealing to a youthful audience. Sporting events such as car races and tennis tournaments are promotional vehicles for cigarettes.⁶ Slim models seem to promise "sexy" vitality from cigarettes.

There are toys which bear cigarette logos. Candy cigarettes and chewing gum cigars still are found in our stores. The most popular brand of bubble gum is an imitation chewing tobacco.⁷ Students learn that smoking is the "adult" thing to do when they are not allowed to smoke on school grounds but teachers are permitted to smoke. (The fervor with which adult smokers cling to smoking lounges only testifies to the addictive nature of their tobacco use.) Government agencies warn against the dangers of tobacco but allow it to be advertised and sold on public property.

4. Easy access to tobacco by children:

A New Jersey law prohibits selling or giving tobacco products to anyone under age 16,⁸ but the Commission has been unable to learn of even one complaint or court case brought under this statute.





The absence of regulatory action is certainly not indicative of widespread compliance with the law. In March 1987, an 11-year old boy readily purchased cigarettes in 19 of 21 attempts without difficulty.⁹ Most tobacco retailers claim unawareness of their precise legal obligations. Cigarettes are readily given to minors during free sampling promotions by cigarette companies. Minors frequently win cigarettes offered as prizes at fairs.

Sales of clove cigarettes, a mixture of cloves and tobacco, are growing. This product's main use may be the initiation of new tobacco users. National experts believe that virtually all clove cigarettes are consumed by minors.¹⁰

Mail-in postcards for free tobacco cigarettes are found in magazine ads from time to time. Children readily can fill out these cards and receive free cigarettes in the mail.

Studies indicate that raising the retail price of tobacco products reduces tobacco consumption by children.¹¹

The use of smokeless tobacco is rapidly increasing, mostly due to a growing demand by males age 13 to 16. The average age of first use is 10 years.¹² At the moment, smokeless tobacco remains free of any excise tax.

Cigarette vending machines are easily accessible to children.

5. Present statewide effort to combat tobacco use in children is insufficient:

Tobacco still is an entrenched part of our culture. Effective protective strategies require resources. Current public expenditures or programs aimed at discouraging initiation of tobacco use by children are miniscule. Private sector expenditures, while larger, are not substantial.

6. Encouraging leadership displayed by a variety of citizens and institutions in New Jersey:

There is a growing interest at a grassroots level to develop and implement innovative programs to prevent tobacco use by the young. Parents and teachers are working toward smoke-free environments for their children and students. It is believed that the testimony on November 19, 1986, indicates a change in public attitude which favors new public policy initiatives.

RECOMMENDATIONS

Based upon the findings presented, the Commis-



sion on Smoking of Health, makes the following recommendations:

• **1. Increase awareness and understanding of smoking as a major threat to the health of our children.**

(a) Incorporate tobacco education and prevention into drug education curricula. Along with the increased coverage of other substance abuse issues in school texts and curricula, tobacco and smoking should be addressed. The portion of the curriculum allotted should reflect its enormous importance relative to other drugs. Curriculum content should emphasize developing skills to resist pressures to smoke and the immediate adverse consequences of tobacco use.

(b) Education for health care professionals who are in direct contact with children should be undertaken. School nurses, counselors, family physicians, pediatricians, obstetricians, and dentists should be taught how to counsel a young patient to quit or to avoid tobacco use.

(c) Improve data collection on children and their tobacco use. The Commission was struck by the paucity of data on tobacco use by young people in New Jersey. The Department of Health should assist the Departments of Education and Law and Public Safety in expanding the coverage of smoking in the Drug and Alcohol use surveys of New Jersey high school students. Focused surveys should be undertaken by the Department of Health to answer specific questions of importance to program development and monitoring.

• **2. Counteract cultural and social influences that encourage tobacco use.**

(a) A vigorous media campaign promoting tobacco-free living should be promoted. Ridiculing tobacco advertising is one innovative approach. Role models appealing to youth, such as sports figures and rock stars might be utilized. Such a campaign would need to be large enough to effectively reduce the use of tobacco by young people.

(b) Persuade sport facilities to refuse tobacco-sponsored events. We believe telecasts of these events may circumvent the federal restrictions on radio and television cigarette advertising.

(c) Eliminate the marketing of candy or bubble gum cigarettes, cigars, pipes, and chewing tobacco in New Jersey. These products help teach children how to use tobacco products. Mock beer, wine or liquor packaged as facsimilies of real products would not be tolerated on the shelves of our stores. Imitation tobacco products should also not be allowed.

(d) Eliminate the marketing of toys and promotional items bearing tobacco trademarks. States have the legal authority to restrict the marketing of a wide array of consumer products. Products

How many cigarettes a day does your child smoke?



When a child breathes air filled with cigarette smoke
it can be as bad as if he actually smoked the cigarette himself.

targeted to very young children which accustom them to tobacco use are unacceptable.

(e) Designate all primary and secondary schools as tobacco-free. Physically separating smokers from nonsmokers within the same enclosed environment diminishes but does not eliminate the exposure of nonsmokers to environmental tobacco smoke.¹³ Allowing anyone to smoke at schools sends a mixed message to children. Allowing teachers to smoke at school reinforces the impression that smoking is an attractive, "adult" thing to do. A double standard is obvious to all when what is said about the drug nicotine and what the faculty is seen to do are inconsistent.

(f) Halt the sale and advertising of cigarettes on state properties and facilities. A state has the authority as a land owner to regulate commerce on its property. Public agencies should have no part in promoting products which are the leading cause of death and which have no socially redeeming value.

• **3. Restrict children's access to tobacco.**

(a) Ban the free distribution of tobacco products. Similar actions have already been taken in Minnesota, Boston, and Atlanta,¹⁴ and have not been challenged in court.

(b) Ban the sale and distribution of clove cigarettes. Some experts believe that clove cigarettes may be more toxic than conventional cigarettes. The major market for this product is children. New Mexico, Nevada, Indiana, and Florida have successfully banned their distribution.¹⁰

(c) Raise the age for legal sale and distribution of cigarettes to age 18 in New Jersey. Current law bans the sale of tobacco to minors 15 years of age and younger. A bill has passed the Assembly amending the law raising the age limit from 16 to 18, explicitly including smokeless tobacco, and raising the fine to \$250. The bill requires posting signs which summarize the law wherever cigarettes are sold or displayed.

Provisions should be added to the law which explicitly state that it is legal to use a minor to purchase tobacco for the purpose of monitoring compliance and enforcement. The penalty should include provision for the suspension and/or loss of license to sell tobacco products. This activity would be administered by the Department of Treasury.

(d) Raise the cigarette excise tax by 5 cents per pack of cigarettes. Tobacco consumption by adolescents experimenting with tobacco is price sensitive.¹¹ The Commission agrees with the observation that, in the narrow economic sense, excise taxes are regressive.¹¹ However, a higher excise tax is justified in light of the enormous societal cost and disease burden produced by smoking. The excise tax is one available tool to reduce tobacco use by children. "Buttlegging" to avoid the excise tax is of concern, but a tax increase of only 5 cents should not make too large an impact because of improved enforcement capabilities in recent years.¹⁵ This would generate an estimated \$40 million in revenue,¹⁶ part of

which could be used to implement recommendations.

(e) Tax smokeless tobacco at the same rate as cigarettes. A 25-cent per unit price rise will reduce consumption of these products by the children and teenagers. An estimated \$5 million might be raised by this tax.¹⁷

(f) Prohibit installation of cigarette vending machines in locations accessible to minors. The National Automatic Merchandising Association estimates that more than 20 percent of New Jersey's cigarette vending machines are in places easily accessible to children,¹⁸ representing approximately 5,000 machines. The Commission was shown no evidence that the vending industry's voluntary program to reduce sales of cigarettes to children has any effect. The only way to insure that vending operators obey the law forbidding the sales of tobacco products to minors is to regulate where such machines can be located or to eliminate them entirely.

(g) Educate tobacco retailers about the illegality of selling tobacco products to minors. Tobacco retailers need to be educated to the addictive nature of tobacco, and the true magnitude of the harm it causes, especially when tobacco use begins in early childhood. The Commission knows of no systematic effort to educate tobacco retailers about the importance of not selling tobacco products to minors. A program to educate tobacco retailers about tobacco and youth should be developed. A variety of methods could be employed: newsletters and trained volunteers visiting individuals and stores are two approaches which could be employed. The measure of success for this undertaking would be an improvement in the observance of the sale-to-minors law. ■

REFERENCES

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3. New Jersey State WIC Program. Trenton, NJ, 1987.
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6. Warner K: *Selling Smoking: Cigarette Advertising and Public Health*. American Public Health Association, Washington, D.C., 1986.
7. Van Metre P: Testimony before the Commission on Smoking or Health, Trenton, NJ, November 19, 1986.
8. N.J.S.A. 2A:170-51, "Sale of Cigarettes, Cigarette Papers or Tobacco to Minors."
9. Personal communication, John D. Slade, MD.
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cigarettes. *Morb Mort Report* 34:31, 1985.

11. Lewit E: Testimony before the Commission on Smoking or Health, Trenton, NJ, November 19, 1986.

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14. National Interagency Council on Smoking and Health: *Smoking Health Reporter* 4:1, 1986.

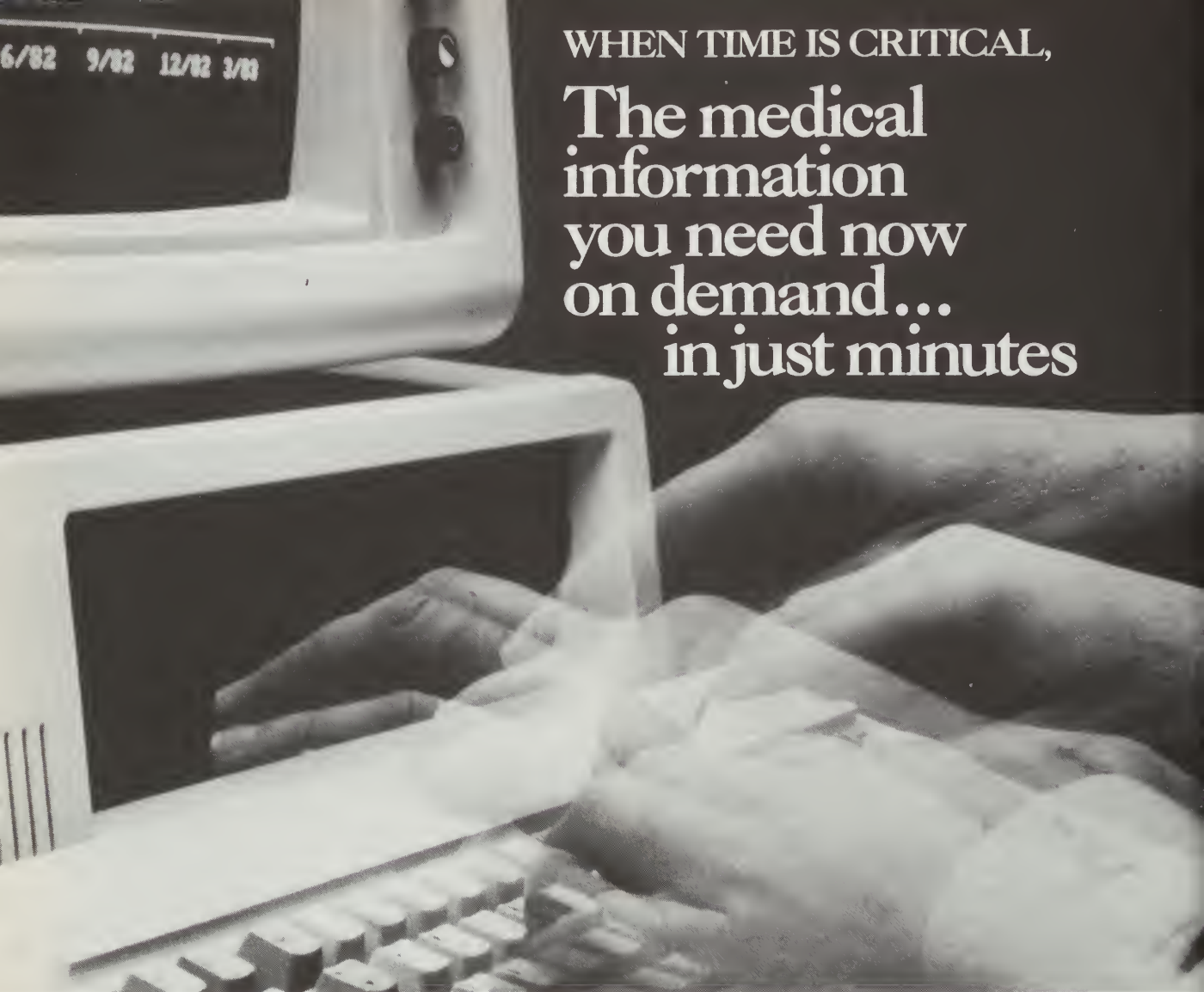
15. Advisory Commission on Intergovernmental Relations: *Cigarette Tax Evasion: A Second Look*. Washington, D.C., 1985.

16. Tobacco Institute: *Cigarette Tax Data*. Washington, D.C., 1986.

17. Triverio C: Testimony before the Commission on Smoking or Health, Trenton, NJ, November 19, 1986.

18. Greenwald Z: Testimony before the Commission on Smoking or Health, Trenton, NJ, November 19, 1986.

19. New Jersey Department of Health: *How Healthy Are New Jerseyans?* Trenton, NJ, 1984.



WHEN TIME IS CRITICAL,

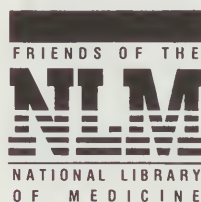
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Address _____

City _____ State _____ Zip _____

**HOUSING APPLICATION
HEADQUARTERS HOTEL**

**Sheraton
Meadowlands Hotel**

Sheraton Plaza Drive, Two Meadowlands Plaza-East Rutherford, N.J. 07073
Sheraton Hotels, Inns & Resorts Worldwide
The hospitality people of ITT

**222nd ANNUAL MEETING
MEDICAL SOCIETY OF NEW JERSEY
Thursday, April 28, to Sunday, May 1, 1988**

_____ Single _____ Double Other _____

Please print or type the following information:

**\$95/Single
\$95/Double
6% NJ State
Sales Tax**

NAME _____

ADDRESS _____

CITY _____

STATE _____ ZIP _____

TELEPHONE NUMBER (_____) _____

ARRIVAL DATE _____ DAY _____

DEPARTURE DATE _____ DAY _____

NAME OF SHARING GUEST _____

CHECK-IN: 3 p.m.

CHECK-OUT: 1 p.m.

CHECK IF OFFICIAL DELEGATE ☐ COUNTY: _____

All reservations will be held until 4 P.M. unless guaranteed with a credit card number or first night's deposit.

Card # _____ Type _____ Exp. Date _____

Sheraton Club International Member Number _____

VISA, MASTERCARD, CARTE BLANCHE, AMERICAN EXPRESS, DINERS CLUB & EN ROUTE
CREDIT CARDS ARE ACCEPTED.

MAIL THIS APPLICATION TO:

Reservations
Sheraton Meadowlands Hotel
Sheraton Plaza Drive, Two Meadowlands Plaza
East Rutherford, NJ 07073
Tel: (201) 896-0500

Reservations must be received by April 6, 1988. Those received after cutoff date will be accepted on a space available basis only.

LOCATION MAP

SHERATON MEADOWLANDS HOTEL

Sheraton Plaza Drive—Two Meadowlands Plaza—East Rutherford, NJ 07073

Tel: (201) 896-0500

How to get to the Sheraton Meadowlands

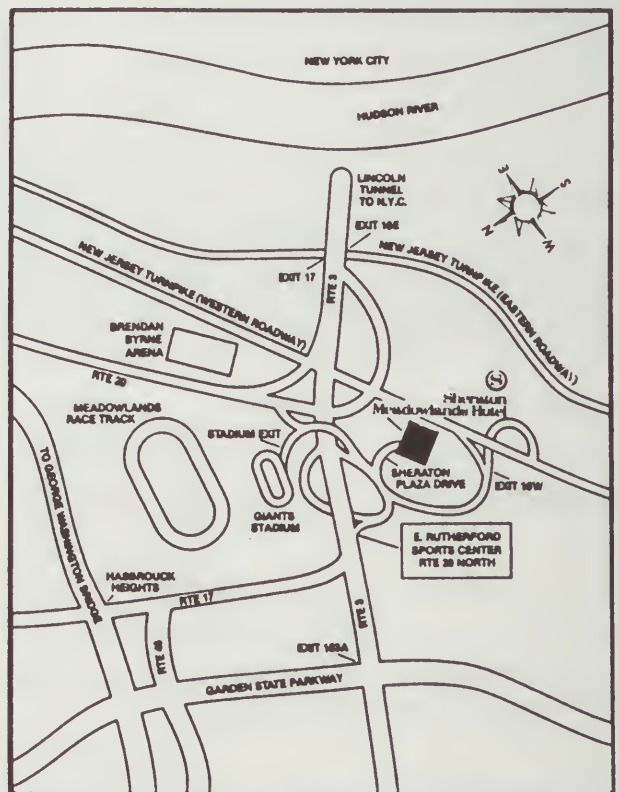
From New York via Lincoln Tunnel: Route 3 W to Sheraton Plaza Drive exit; follow signs to hotel.

From New Jersey Turnpike (N or S): Exit 16 W; follow signs to Route 3 E; stay on service road and follow signs for Sheraton Plaza Drive.

From New York via G. W. Bridge: Take I-95 (N.J. Turnpike) S; exit 16 W and follow as above.

From Garden State Parkway (N or S): Exit 153A to Route 3 E to Route 20 N (Arena) exit; follow signs for Sheraton Plaza Drive.

From Route 17 (N or S): Exit Route 3 E and follow as above.



**Trustees' Minutes; UMDNJ
Notes; AMNJ Report;
Physicians Seeking
Location in New Jersey**

**Trustees' Minutes
December 20, 1987**

A regular meeting of the Board of Trustees was held on Sunday, December 20, 1987, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Report of the President . . . Noted that the task force on AIDS, which has been charged with recommending policy and providing continuing medical education on AIDS to New Jersey physicians, will meet on January 13, 1988.

Report of Executive Director . . .

(1) MSNJ Paid Membership . . . Noted that at this time paid 1987 memberships total 7,592.

(2) MSNJ Financial Statements . . . Approved the financial statements for the periods ending October 31, 1987, and November 30, 1987.

(3) AMA Advisors, Inc.—Committee on Membership Services . . . Was unanimously in favor of endorsement of AMA Advisors, Inc.; the program soon will be implemented.

(4) Tort Reform . . . Noted that bills on tort reform, structured payments, and statute of limitations reintroduced in the 1988 session of the legislature are expected soon.

(5) State Commission of Investigations (SCI) Report/Legislative Hearings . . . Noted that the Executive Committee agreed to retain Judge Herbert Stern to represent MSNJ in activity related to the SCI report and the impending legislative thrust.

(6) Blue Shield Contract Analysis . . . Will be advised when William P. Isele, Esq. completes a report on whether or not the interpretation of the participating physician agreement as related to Pace and Medallion programs is valid.

(7) General Liability Coverage to County Medical Societies . . . Noted that general liability coverage will be provided through MSNJ by endorsement to the existing general liability package.

(8) Optometric Drug Bill—S-2261 . . . Noted that S-2261, a bill which would grant optometrists the right to prescribe drugs, failed to receive the necessary votes.

(9) Physical Therapy Board Scope of Practice Rule . . . Noted that MSNJ will proceed with litigation, challenging the Physical Therapy Board regulation, without the assistance of the State Board.

(10) Preadmission Certification Programs/Utilization Review . . . Noted that the ultimate hope in this matter is that a system can be achieved whereby all preadmission certification and reviews are performed by the existing utilization review organizations.

UMDNJ Report . . .

(1) Resident Permits . . . Noted that UMDNJ is opposed to the rule proposal of the State Board of Medical Examiners on the issuance of resident permits, stating the paperwork would be overwhelming and would discourage good candidates from taking residencies in New Jersey.

(2) Resident Work Hours . . . Noted that recommendations have been made to the New York Commissioner of Health concerning limitations on resident work hours and parameters of supervision for residents in an educational setting.

(3) Foreign Medical Graduate Testing . . . Noted that the Educa-

tion Council for Foreign Medical Graduates has decided to proceed with clinical skills assessment as part of their examination.

NJ Hospital Association . . .

(1) Medical Waste Disposal . . . Noted a four-part program to address the problem of medical waste disposal consisting of: legislation; licensing of handlers; fines for improper disposal; and documentation system.

(2) AIDS . . . Noted that the NJHA Board of Trustees has appointed a special AIDS Task Force.

(3) Financial Crisis: New Jersey Hospitals . . . Unanimously approved the following recommendation:

That the Medical Society support a request to the Hospital Rate-Setting Commission, the Governor, and the Legislature to increase the base rate of reimbursement to hospitals in New Jersey with sufficient monies that the New Jersey Hospital Association data can support, to provide quality care for the citizens of New Jersey.

Approved the following recommendation:

That the President of the Medical Society of New Jersey write a letter to the Governor asking for his support in creating a committee for study of the crisis in the allied health technology fields.

Council on Legislation . . .

(1) Current State Legislation . . . Approved the following recommendation, with the exception of S-3498 and S-3633.

That the Board of Trustees approve the positions recommended by the Council on Legislation.

Noted that S-3498 creates a 15-member Commission to study services to patients with osteoporosis and changed position to "No Action." Noted that S-3633 requires health insurers to offer wellness incentives; changed position to "No Action."

Council on Mental Health . . . Adopted the following resolution:

That the Medical Society of New Jersey encourage the practice of consultation with a psychiatrist for evaluation, assessment, and recommendations before referring to nonmedical mental health professionals in the course of treating a patient with a mental illness.

Council on Public Health . . . Approved the following recommendation:

That the Medical Society of New Jersey sponsor an educational seminar for physicians on counseling related to HIV testing.

Also, approved the following three recommendations:

That the Medical Society of New Jersey endorse the concept of multidisciplinary consultation by diverse medical specialties such as surgery, medicine, radiation therapy, and pathology in the evaluation and management of cancer patients.

That the Medical Society of New Jersey endorse the American College of Surgeons approval program, including the multidisciplinary tumor board/conference and the hospital tumor registry.

That all hospitals be encouraged to participate in the program and seek full approval.

Committee on Membership Services . . . Approved the following recommendations:

That the Medical Society of New Jersey endorse the concept of the Peer Review Organization Legal Representation Program.

That the Medical Society of New Jersey endorse the Disability Income Protection Program offered by the Paul Revere Life

Insurance Company through the International Underwriters Agency.

That the Medical Society of New Jersey endorse the auto leasing program through Automotive Rentals, Inc.

That a professional printed informational folder containing all the endorsed programs offered by the Society be prepared and distributed to the membership.

Committee on Membership Services . . .

(1) Long-Term Nursing Care Insurance . . . Approved the following recommendation:

That the Medical Society of New Jersey endorse the individual long-term nursing care insurance available through Aetna and administered by Donald F. Smith & Associates.

(2) Blue Cross/Blue Shield, Major Medical and Dental Insurance Programs—Rate Increases . . .

(a) Blue Cross/Blue Shield . . . Noted that actual increases will vary by program and type of contract and therefore may be more or less than 25.34 percent.

(b) Major Medical . . . Noted that premium rates must be increased by an average of 34 percent, effective January 1, 1988.

(c) Dental . . . Noted that a refund of almost 25 percent of premiums

will be returned to participants, but noted that program costs in 1988 are projected to rise and a 9 percent increase will take effect January 1, 1988. Also, noted the Committee will review programs available through commercial insurers interested in underwriting the MSNJ group.

(3) Underwriting Changes in MSNJ Blue Cross/Blue Shield and Major Medical Insurance Programs . . . Changes in these programs appear on page 86.

Committee on Biomedical Ethics . . . Approved the following recommendations:

That representatives of the Citizens Committee on Biomedical Ethics, the New Jersey Hospital Association, and the Committee on Biomedical Ethics work together on a joint venture using the Pennsylvania Medical Society's "Do Not Resuscitate Guidelines."

That the composition of the Committee on Biomedical Ethics be expanded to include, as consultants, individuals who already have made biomedical decisions (i.e., the Commissioner of Health, decision judges, medical students, and representatives from the Citizen's Committee on Biomedical Ethics, and the New Jersey Hospital Association).

That a mechanism be developed to educate physicians on the policies created by the Committee on Biomedical Ethics and to follow up on their implementation.

That clinically oriented biomedical updates be featured in the newsletter or editorial sections of *NEW JERSEY MEDICINE*.

Special Committee on Emergency Medical Care . . . Approved the following recommendation:

That the Medical Society of New Jersey approve the report "New Jersey Emergency Medical Services Issues and Recommendations Phase I" and urge the state to implement the "911" emergency system as soon as possible.

Special Committee on Long-Range Planning and Development . . . Approved the following recommendation:

That prior to being interviewed by the Nominating Committee, candidates *may* submit a written statement as to why they believe they are qualified to represent the physicians of New Jersey in the office they are seeking; and also enclose their recent photograph. The material is to be included as part of the permanent records of the Nominating Committee and be available for examination by the nominating delegates at any time. (*Italics denote rewording.*)

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Category: (Please check one)

- ☐ Member, MSNJ
- ☐ Subscriber, NJ Medicine
- ☐ Other _____

Name _____

Old Address _____

City _____ State _____ Zip _____

New Address _____

City _____ State _____ Zip _____

Special Committee on Drugs and Alcohol Abuse . . . Approved the following recommendation:

That the Board of Trustees approve the Executive Summary Report of the Commission on Smoking or Health.

Committee on Medical Education . . . The following recommendation was approved.

That the Committee on Medical Education be authorized to meet with representatives of the State Board of Medical Examiners to discuss the proposed regulation on registration and permit requirements for graduate medical education programs.

Unfinished Business . . .

Task Force on AIDS . . . Noted that this Task Force will deal with the development of policies and protocol vis-a-vis physicians diagnosed as having AIDS, or found to have a positive HIV titer.

New Business . . .

State Board of Medical Examiners Policy on AIDS . . . Received the State Board's policy on AIDS.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

I would like to examine another aspect of our top 25 efforts: educational excellence. High-quality educational programs are the most basic element in the foundation required for a top-ranked health sciences university, and in recent years, excellence in minority education has developed as a strong corollary need. UMDNJ has achieved both, as demonstrated by the following statistics:

- Students at both of UMDNJ's allopathic medical schools have scored well above the national mean on national licensing examinations in each of the last seven years. The University's osteopathic school regularly ranks first or second in the nation in student performance on board examinations, while students of our dental school rank among the best in the Northeast region for the last five years.

- Students of the UMDNJ-School of Health Related Professions do equally well on their professional licensure tests. The University's Physicians Assistant program ranked first in the nation in 1986

for student performance, and has ranked among the top ten in every year since 1979. Nurse midwifery graduates averaged 560 on their certification examination against a passing national score of 375, and graduates of the Dietetic Internship program score well above the national mean.

- UMDNJ's two allopathic medical schools enroll 20.4 percent minority students as compared to an average of 8.65 percent in all United States medical schools, according to 1986 statistics from the American Association of Medical Colleges. While UMDNJ's students account for 3.75 percent of all medical students, the University enrolls 8.9 percent of all minority medical students in the nation.

- UMDNJ's residency training programs include 25 percent minority physicians as compared to 17 percent nationally. While UMDNJ trains 1.5 percent of the nation's medical residents, its programs account for 2.2 percent of all minority physicians in residencies.

- While national statistics reveal that only 80 percent of all medical school graduates were accepted in a matched residency program in their first year after graduation in 1986, 98 percent of the University's medical graduates received residencies; 88 percent of UMDNJ's minority graduates were placed.

UMDNJ has established itself as a national leader in the recruitment and retention of minority students, maintaining an enrollment of 20 percent minority students University-wide over the past 15 years. In addition, the University has pioneered in the development of enrichment programs designed to help disadvantaged students prepare for, and succeed in, medical and dental schools. Its nationally acclaimed Students for Medicine and Dentistry program has launched thousands of minority young people on professional careers in the health sciences at universities across the nation.

New Jersey needs a top-ranked health sciences university as an integral element in a world-class system of higher education. Much of the progress New Jersey has made over the past decade in advancing and improving its higher education system has been built upon linkages among programs and institutions, and UMDNJ has played a central role

in these initiatives. If higher education in New Jersey is to continue its development, a top 25 health sciences institution will be vital to its success. But most of all, a top ranked health sciences university will mean that New Jersey students will receive the highest quality health sciences education and that the state will have the highest caliber health professionals.

AMNJ Report

Anthony Minnefor, M.D.
President

The Academy is pleased to announce that we have expanded our relationship with the Healthcare Information Network (HIN) in Princeton. The "From the Academy" series will include on-site filming of procedures which will be incorporated into the studio interview format which has proved successful. We expect that this innovation significantly will enhance the interest in the programs. We are pleased that Dr. Joseph Lieberman will continue to act as moderator for the monthly series.

In addition, we have worked out an agreement with HIN to assist in the coordination of the MSNJ Professional Liability Forum. The Academy will provide mediated materials and an examination for each program which will insure meeting the criteria for category I credit.

The Second Annual Governor's Jersey Pride Awards Program will culminate on Thursday, January 7, 1988, with the presentation of 11 awards to distinguished New Jerseyans. The Governor's Award Ceremony will take place at 8:00 P.M. at Princeton's McCarter Theatre and an entertaining and inspirational evening is planned. The Academy is responsible for recommending nominees for the Clara Barton Medical Service Award. Award recipients will be announced in early December.

The Academy continues to provide a significant amount of continuing medical education programs for professionals involved with AIDS patients. A highlight of this effort will be a March 16, 1988, major symposium, "AIDS: The Physician and the Patient," to be cosponsored with MSNJ and the New Jersey State Department of Health. The program will examine counseling, ethical, and medicolegal issues and will include an AIDS patient on the agenda.

Further information will be forthcoming on this event.

The *New Jersey Physicians Golf Association* completed a successful inaugural year under the aegis of the Academy. Drs. Peter Tsairis and Steve Fletcher have been elected Chairman and Secretary, respectively, for the 1988 season. Plans are underway to hold six tournaments and a membership solicitation flyer was distributed with the Academy's Newsletter in December. Further information can be obtained by contacting Cal Heitzmann, Executive Director, at the Executive Offices.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Daniel O'Brien, M.D., 12 Beech Dr., Brunswick, ME 04011. Liege (Belgium) 1975. Board

certified. Group, partnership, solo. Available.

CARDIOLOGY—Richard Don Diego, M.D., 6020 Danny Kaye, #906, San Antonio, TX 78240. Central Caribbean (Puerto Rico) 1981. Also, internal medicine. Board eligible. Group or partnership. Available July 1988.
Govindaraju Subramani, M.D., 4250 N. Marine Dr., Apt. 506, Chicago, IL 60613. Wisconsin 1987. Board eligible. Partnership or group. Available.

FAMILY MEDICINE—William B. Glenn, D.O., 2 Raintree Way, Havelock, NC 28532. Philadelphia College 1980. Board certified. Group, partnership, solo. Available July 1988.
Chava Zimmerman, M.D., 127F Amberly Dr., Manalapan, NJ 07726. Wayne State 1978. Board certified. Group or HMO. Available July 1988.

GASTROENTEROLOGY—Joel H. Kurtz, M.D., 2600 Netherland Ave., Apt. 2811, Riverdale, NY 10463. UMDNJ 1983. Board eligible. Partnership or group. Available July 1988.

INTERNAL MEDICINE—Glenn A. Dubov, M.D., 75-36 Bell Blvd., Apt. 2A, Bayside, NY 11364. Chicago 1983. Board certified. Group or partnership. Available July 1988.
Kathy Rosen Kerr, M.D., 318 Perrine Ave., Piscataway, NJ 08854. UMDNJ

1984. Also, pediatrics. Board eligible. Partnership or small group. Available July 1988.

Daniel R. Massarelli, M.D., 98 Longfellow Rd., Worcester, MA 01602. Georgetown 1985. Board eligible. Group, partnership, solo. Available September 1988.

Sarva Daman Singh, M.D., 26 Carlson Ct., Closter, NJ 07624. Agra (India) 1978. Board eligible. Group or partnership. Available.

Samuel J. Stepanow, M.D., 430 W. Browning Rd., Apt. S-5, Bellmawr, NJ 08031. Hahnemann 1985. Board eligible. Group or partnership. Available July 1988.

Dariusz Sypek, M.D., 154 Oakwood Ave., Apt. 3, Cliffside Park, NJ 07019. Medical Academy (Poland) 1984. Board eligible. Group. Available July 1988.

NEPHROLOGY—Glenn A. Dubov, M.D., 75-36 Bell Blvd., Bayside, NY 11364. Chicago 1983. Also, internal medicine. Board certified (IM). Group or partnership. Available July 1988.

OPHTHALMOLOGY—James Scott Lewis, M.D., 531 Sprague Rd., Narberth, PA 19072. Jefferson 1982. Group, partnership, solo. Available.

PEDIATRICS—Sheth Amit, M.D., 1305 East 18 St., Brooklyn, NY 11230. N.H.L. Municipal (India) 1982. Board eligible. Group, partnership, solo. Available July 1988.
Kathy Rosen Kerr, M.D., 318 Perrine Ave., Piscataway, NJ 08854. UMDNJ 1984. Also, internal medicine. Board eligible. Partnership or small group. Available July 1988.

PULMONARY—Martin J. Greenberg, M.D., 76 Church St., Montclair, NJ 07042. Ross 1983. Board eligible. Partnership or group. Available July 1988.

RADIOLOGY—Charles Saniewski, M.D., 9261 E. Bay Harbor Dr., #8, Bay Harbor, FL 33154. Rome 1983. Board eligible. Group or partnership. Available July 1988.

SURGERY—Victor B. Lebedovych, M.D., 211 S. Crapo St., Mt. Pleasant, MI. Michigan 1968. Board certified. Partnership or association. Available.
Robert M. O'Brien, M.D., 182 Estates Dr., Piedmont, CA 94611. Vermont 1958. Also, noncardiac thoracic surgery. Board certified. Group, partnership, solo, in southern New Jersey only. Available.
Ramiro Requena, M.D., Interfaith Medical Center, 555 Prospect Place, Brooklyn, NY 11238. Bolivia 1966. Board certified. Group, partnership, solo. Available.

UROLOGY—Charles Dorfman, M.D., 3313 Amherst Rd., Erie, PA 16506. Universidad Central del Este (Mexico) 1980. Board eligible. Group or partnership. Available July 1988.

MEDICAL SOCIETY OF NEW JERSEY ANNUAL MEETING

Wednesday, April 27, 1988

3:30 p.m.—Board of Trustees' Meeting

Thursday, April 28, 1988

9:00 a.m.—Registration Opens
9:00 a.m.—Message Center Opens
1:00 p.m.—Exhibits Open
2:00 p.m.—House of Delegates
3:30 p.m.—Reference Committees

Friday, April 29, 1988

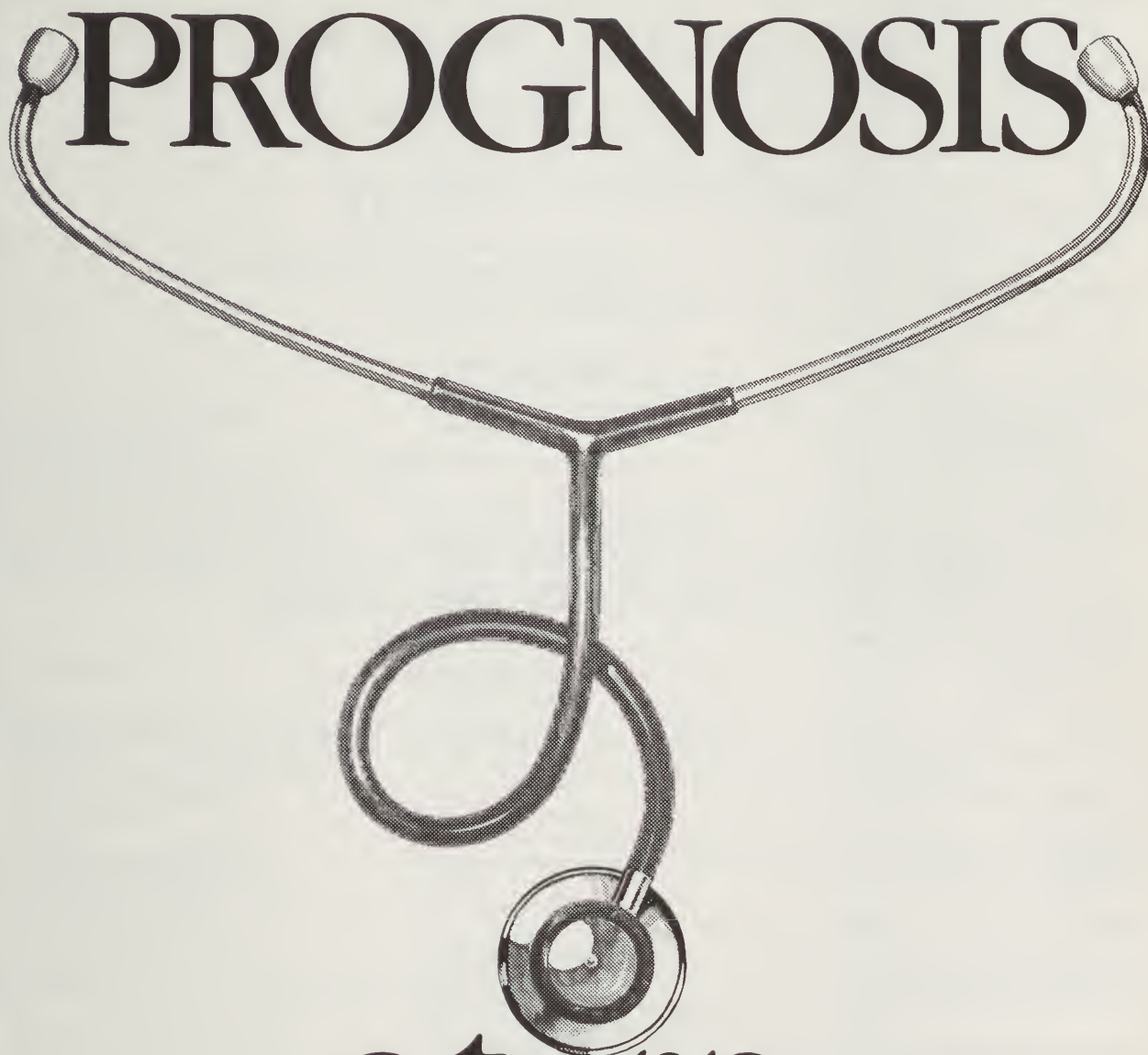
8:00 a.m.—Registration Opens
8:00 a.m.—Message Center Opens
8:30 a.m.—Exhibits Open
9:00 a.m.—House of Delegates (election)
12:00 noon—Golden Merit Award Ceremony followed by Reception
2:30 p.m.—Reference Committees
5:00 p.m.—JEMPAC Political Forum
5:45 p.m.—JEMPAC Wine and Cheese Reception

Saturday, April 30, 1988

8:00 a.m.—Registration Opens
8:00 a.m.—Message Center Opens
8:30 a.m.—Exhibits Open
9:00 a.m.—House of Delegates
1:30 p.m.—House of Delegates
6:00 p.m.—Inaugural Reception followed by Inaugural Dinner

Sunday, May 1, 1988

8:00 a.m.—Registration Opens
8:00 a.m.—Message Center Opens
8:30 a.m.—Program on one topic of major interest to the physician
1:00 p.m.—Board of Trustees' Meeting



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CARDIOLOGY UPDATE . . .

designed for the Physician and provides an intensive survey of the
current status of Clinical Cardiology . . .

WEDNESDAY
MARCH 2, 1988
3:00 to 5:00 PM

DIAGNOSIS AND MANAGEMENT OF
NON-CORONARY DISORDERS

MODERATOR: BERNARD L. SEGAL, M.D.

3:00-3:20	Cardiac involvement in anemias and connective tissue disorders	Warren Katz, M.D.
3:20-3:40	The athlete and the heart	Garo S. Garibian, M.D.
3:40-4:00	Congenital heart diseases in the adult	Bernard L. Segal, M.D.
4:00-4:30	Case presentations	Jonathan Gomberg, M.D.
4:30-5:00	Panel discussion	Michael V. Yow, M.D.; Ami S. Iskandrian, M.D.

- No Registration Fee
- No Advance Registration Required
- CME Credits*

* * Refreshments Served Following Each Session * *

Scheie Eye Institute Auditorium
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Medical Center
39th and Market Streets
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*The University of Pennsylvania School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing education for physicians. The University of Pennsylvania School of Medicine designates this continuing medical activity for 2 credit hours per session in Category 1 of the Physician's Recognition Award of the American Medical Association.

CME CALENDAR

The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization for further information.

ANESTHESIOLOGY

March

- 2 Does Choice of Anesthetic Make a Difference?**
8-8:50 A.M.—Robert Wood Johnson Medical School, MEB-593, New Brunswick (UMDNJ)
- 12- 29th Annual Postgraduate**
- 13 Anesthesia Seminar**
Hyatt Hotel, Cherry Hill (New Jersey State Society of Anesthesiologists)

CARDIOLOGY

March

- 1 Advanced Cardiac Life-Support**
- 3 Provider Course**
28 New Jersey Medical School, MSB,
- 29 B-648, Newark**
- 31 (UMDNJ)**
- 3 Cardiology Grand Rounds**
10 12 noon—Robert Wood Johnson
- 17 Medical School, Academic**
- 24 Health Science Center,**
New Brunswick (UMDNJ)
- 17 New Approaches to the Management of Heart Failure**
5 P.M.—Fuld Auditorium, Somerset Medical Center, Somerville (Somerset Medical Center)

DERMATOLOGY

March

- 2 Common Problems in Dermatology**
1:30-2:30 P.M.—Health Maintenance Organization, New Brunswick (Rutgers Community Health Plan)
- 8 Dermatology Lecture**
8-10 P.M.—Schering Corporation, Kenilworth (The Dermatological Society of New Jersey)

- 16 Dermatology-I**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth (Alexian Brothers Hospital)
- 23 Dermatology-II**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth (Alexian Brothers Hospital)
- 30 Common Skin Disorders**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth (Alexian Brothers Hospital)

April

- 12 Dermatology Lecture**
8-10 P.M.—Schering Corporation—Kenilworth (The Dermatology Society of New Jersey)
- 20 Dermatology Conference**
6-9 P.M.—Rutgers Community Health Plan, New Brunswick (UMDNJ)

MEDICINE

March

- 2 Drug Addiction: Chronic Pain Management and Other Issues**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic (St. Mary's Hospital)
- 2 Drug Interactions**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth (Alexian Brothers Hospital)
- 3 Disease Associated with Exposure to Asbestos**
4-6 P.M.—Coriell Institute, Camden (Coriell Institute)
- 4 Alzheimer's Disease**
12 noon-1 P.M.—Bridgeton General Hospital, Bridgeton (AMNJ)
- 5 Endocrine Series**
11:30 A.M.-1 P.M.—VA Medical Center, East Orange (AMNJ)
- 7 Rheumatology Staff Conference**
5:30-7 P.M.—Robert Wood Johnson Medical School, MEB-393, New Brunswick (UMDNJ)
- 8 Laser Treatment of GI Hemorrhage**
12 noon-1 P.M.—Hospital Center at Orange (AMNJ)
- 8 Grand Rounds**
15 9-10 A.M.—Holy Name Hospital,
- 22 Marian Hall, Teaneck**
- 29 (Holy Name Hospital)**
- 9 Medical Grand Rounds**
16 10 A.M.—St. Mary Hospital,
- 23 Hoboken**
(St. Mary Hospital)
- 9 Management of Abdominal Emergencies**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic (St. Mary's Hospital)
- 9 Alzheimer's Disease**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove (AMNJ)
- 10 Scientific Meeting**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston

(New Jersey Institute of Ultrasound in Medicine)

- 14 Medical Aspects of Alcohol Abuse**
2-3 P.M.—Forensic Psychiatric Hospital, Trenton (Forensic Psychiatric Hospital)
- 15 Anion Gaps—Urine, Blood, and Stool**
4-5 P.M.—Robert Wood Johnson Medical School, New Brunswick (UMDNJ)
- 16 Nephrotoxicity of Common Drugs**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic (AMNJ)
- 16 Use of Second Generation Oral Agents**
10:30-11:30 A.M.—Christ Hospital, Jersey City (Christ Hospital)
- 16 Ramifications and Implications of the New Jersey Controlled Dangerous Substance Act**
8:30 P.M.—Passaic County Medical Society, Clifton (Passaic County Medical Society)
- 17 Indoor Air Pollution: Public Health Perspective**
4-6 P.M.—Coriell Institute, Camden (Coriell Institute)
- 17 Physical Assessment of Severely Disabled**
1:30-2:30 P.M.—Vineland Developmental Center Hospital (AMNJ)
- 17- 36th Annual Convention:**
- 20 Family Practice**
Bally's Park Casino Hotel, Atlantic City
- 17 American Academy of Allergy and Immunology**
11 A.M.—Children's Hospital, Newark (UMDNJ)
- 18 Gastroenterology—Peptic Ulcer**
10:30-11:30 A.M.—Woodbridge Developmental Center (AMNJ)
- 24 Radon: Consequences of Human Exposure**
4-6 P.M.—Coriell Institute, Camden (Coriell Institute)
- 24 Proper Use of Antibiotics**
1:30-2:30 P.M.—Hunterdon Developmental Center, Clinton (AMNJ)
- 24 Visiting Professor Program**
1:30-2:30 P.M.—Saint Barnabas Medical Center, Livingston (Saint Barnabas Medical Center)

April

- 2 Endocrine Series**
11:30 A.M.-1 P.M.—VA Medical Center, East Orange (AMNJ)
- 4 Rheumatology Staff Conference**
5:30-7 P.M.—Robert Wood Johnson Medical School, MEB-393, New Brunswick (UMDNJ)
- 6 The Otto Brandman M.D. Award Ceremony**
6-11 P.M.—The Hyatt Regency, New Brunswick (American Diabetes Association)

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Patients**

on

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at

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**ANTHONY MINNEFOR, M.D.
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**President, The Academy of Medicine of New Jersey
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St. Joseph's Hospital & Medical Center**

For Further Information on Registration, Faculty & Fees,
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- 6 Approach to the Patient with Joint Pain**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth
(*Alexian Brothers Hospital*)
- 7 Toxin Exposure and Risk Assessment**
4-6 P.M.—Coriell Institute, Camden
(*Cortell Institute*)
- 7 Functional Assessment of the Elderly**
2-3 P.M.—John E. Runnells Hospital of Union County, Berkeley Heights
(*AMNJ*)
- 11 Invasive Hemodynamic Monitoring**
7-8 P.M.—Wallkill Valley General Hospital, Sussex
(*AMNJ*)
- 13 Medical Grand Rounds**
20 10 A.M.—St. Mary Hospital,
27 Hoboken
(*St. Mary Hospital*)
- 13 Septic Shock**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(*AMNJ*)
- 13 Nephrotoxicity of Common Drugs**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(*AMNJ*)
- 13 Dilemmas in Osteoporosis**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth
(*Alexian Brothers Hospital*)
- 14 Human Population Monitoring**
21 4-6 P.M.—Coriell Institute,
28 Camden
(*Cortell Institute*)
- 19 AIDS, the Kidney, and Dialysis**
4-5 P.M.—Robert Wood Johnson Medical School, MEB, New Brunswick
(*UMDNJ*)
- 20 Nutritional Support**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(*AMNJ*)
- 20 Indications and Counterindications to Lithotripsy**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth
(*Alexian Brothers Hospital*)
- 21 Cytogenetic Monitoring of Exposed Populations**
4-6 P.M.—Coriell Institute, Camden
(*Cortell Institute*)
- 21 Clinical Importance of New GI Hormones**
5-6 P.M.—Fuld Auditorium, Somerset Medical Center, Somerville
(*Somerset Medical Center*)
- 27 Transplants**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(*Christ Hospital*)
- 28 Nutritional Assessment**
3-4 P.M.—Ancora Psychiatric Hospital, Hammonton
(*AMNJ*)
- 28 Visiting Professor Program**
1:30-2:30 P.M.—Saint Barnabas Medical Center, Livingston
(*Saint Barnabas Medical Center*)

NEUROLOGY

March

- 9 Alzheimer's Disease**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(*AMNJ*)

OBSTETRICS/GYNECOLOGY

March

- 24 Perinatal Conference**
7-9 P.M.—Newcomb Medical Center, Vineland
(*Newcomb Medical Center*)
- 25 Annual Semmelweis-Waters Ob/Gyn Conference**
Resorts International Hotel, Atlantic City
(*UMDNJ*)
- April**
- 14 Joint Meetings**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(*Radiological Society of NJ, NJ Institute of Ultrasound, AMNJ*)
- 28 Perinatal Conference**
7-9 P.M.—Newcomb Medical Center, Vineland
(*Newcomb Medical Center*)

ONCOLOGY

March

- 2 Scientific Dinner Meeting**
16 6:30-9:30 P.M.—The Manor,
30 West Orange
(*AMNJ*)
- 3 Tumor Board Conferences**
10 9-11 A.M.—Irvington
17 General Hospital
24 (*Irvington General Hospital*)
31
- 4 Cancer Research Colloquium**
11 12 noon-1:15 P.M.—New Jersey
18 Medical School, MSB, G-506b,
25 Newark
(*UMDNJ*)
- 7 Hematology/Oncology Conference**
21 12 noon-1 P.M.—Robert Wood Johnson Medical School, MEB-108A, New Brunswick
(*UMDNJ*)
- 9 Ninth Annual Tumor Board Conference**
6-9 P.M.—MSNJ Headquarters, Lawrenceville
(*The Oncology Society of New Jersey*)
- 10 Studies on the Mechanism of Action of 2, 3, 7, and 8—Tetrachlorodibenzo-P-Dioxin: Receptor Mediated Toxicity**
4-6 P.M.—Coriell Institute, Camden
(*Cortell Institute*)
- 21 Hematology/Oncology Conference**
12 noon-1 P.M.—Robert Wood Johnson Medical School, New Brunswick
(*UMDNJ*)
- 24 Tumor Board Conferences**
12 noon—Newcomb Medical Center, Vineland
(*Newcomb Medical Center*)

April

- 4 Hematology/Oncology Conference**
18

12 noon-1 P.M.—Robert Wood Johnson Medical School, MEB-108A, New Brunswick
(*UMDNJ*)

- 7 Tumor Board Conferences**
14 9-11 A.M.—Irvington
21 General Hospital
28 (*Irvington General Hospital*)
- 8 Cancer Research Colloquium**
15 12 noon-1:15 P.M.—New Jersey
22 Medical School, MSB, G-506B,
29 Newark
(*UMDNJ*)
- 13 Scientific Dinner Meeting**
27 6:30-9:30 P.M.—The Manor, West Orange
(*AMNJ*)
- 28 Tumor Board Conferences**
12 noon—Newcomb Medical Center, Vineland
(*Newcomb Medical Center*)
- 28 In Vivo Gene Mutations in Human T Lymphocytes**
4-6 P.M.—Coriell Institute, Camden
(*Cortell Institute*)

ORTHOPEDICS

March

- 3 Orthopaedic Grand Rounds**
10 7:30-9 A.M.—Robert Wood Johnson
17 Medical School, New Brunswick
24 (*UMDNJ*)
31
- April**
- 6 Sports Medicine**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(*AMNJ*)
- 7 Orthopaedic Grand Rounds**
14 7:30-9 A.M.—Robert Wood Johnson
21 Medical School, New Brunswick
28 (*UMDNJ*)
- 19- 1988 Annual Spring Meeting**
24 Aruba Palm Beach Hotel and Casino, Aruba
(*New Jersey Orthopaedic Society*)

PATHOLOGY

March

- 1 Renal Pathology Conference**
12 noon-1 P.M.—Robert Wood Johnson Medical School, New Brunswick
(*UMDNJ*)
- 17 Hematopathology Conference**
4-5 P.M.—Saint Peter's Medical Center, New Brunswick
(*Muhlenberg Medical Center*)

April

- 5 Renal Pathology Conference**
12 noon-1 P.M.—Robert Wood Johnson Medical School, New Brunswick
(*UMDNJ*)
- 21 Hematopathology Conference**
4-5 P.M.—Robert Wood Johnson Medical School, New Brunswick
(*Muhlenberg Medical Center*)

PEDIATRICS

March

- 3 Pediatric Immunology/Allergy**
10 11 A.M.-12 noon—Children's Hospital of New Jersey, Newark
(*UMDNJ*)

- 3 Pediatric Grand Rounds**
10 8:30-9:30 P.M.—Robert Wood
17 Johnson Medical School, MEB-102,
24 New Brunswick
31 (UMDNJ)
- 4 Advances in Pediatrics**
11 9:30-10:30 A.M.—New Jersey
18 Medical School, MSB, B-610,
25 Newark
 (UMDNJ)
- 8 Case Conferences**
15 8-9 A.M.—Robert Wood Johnson
22 Medical School, MEB-108A,
29 New Brunswick
 (UMDNJ)
- 18 Diagnosis and Management of the Malabsorption Syndromes**
 8 A.M.-12 noon—Overlook Hospital, Summit
 (Overlook Hospital)

April

- 5 Case Conferences**
12 8-9 A.M.—Robert Wood Johnson
19 Medical School, MEB-108A,
26 New Brunswick
 (UMDNJ)
- 7 Pediatric Grand Rounds**
14 8:30-9:30 P.M.—Robert Wood
21 Johnson Medical School, MEB-102,
28 New Brunswick
 (UMDNJ)

- 8 Advances in Pediatrics**
15 9:30-10:30 A.M.—New Jersey
22 Medical School, MSB, B-610,
29 Newark
 (UMDNJ)
- 13 Cranofacial Abnormalities**
 8 A.M.-4 P.M.—Children's Specialized Hospital, Mountainside
 (Children's Specialized Hospital)
- 15 Cardiac Arrhythmias in the Pediatric Age Group**
 8 A.M.-12 noon—Overlook Hospital, Summit
 (Overlook Hospital)

PSYCHIATRY

March

- 3 Developmental Disabilities**
 10-11 A.M.—Green Brook Regional Center
 (AMNJ)
- 4 Alzheimer's Disease**
 10:45-11:45 A.M.—Greystone Park Psychiatric Hospital, Greystone
 (AMNJ)
- 5 Case Seminars**
19 8-10 P.M.—312 Harding Drive, South Orange
 (Advanced Psychiatric Study Group)

- 7 Treatment of Resistant Depression**
 8:15 P.M.—326 Park Street, Montclair
 (Essex Psychiatric Seminars)
- 18 Treatment of Insomnia**
 8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth
 (Alexian Brothers Hospital)
- 19 Scientific Meeting**
 7:30 A.M.—Saint Barnabas Medical Center, Livingston
 (NJ Psychoanalytic Society)
- 19 Clinical Issues in Human Sexuality—An Update on Drugs, Diseases, and Devices**
 5-6:30 P.M.—Fuld Auditorium, Somerset Medical Center, Somerville
 (Somerset Medical Center)
- 24 Psychopharmacology**
 2:30-3:30 P.M.—New Lisbon Developmental Center, New Lisbon
 (AMNJ)
- 25 Depression in the Elderly**
 8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth
 (Alexian Brothers Hospital)

April

- 2 Case Seminars**
16 8-10 P.M.—312 Harding Drive, South Orange
 (Advanced Psychiatric Study Group)
- 4 A Case of Cocaine Addiction**
 8:15-10:15 P.M.—39 Crescent Avenue, Passaic
 (Essex Psychiatric Seminars)
- 16 Scientific Meeting**
 Saint Barnabas Medical Center
 (NJ Psychoanalytic Society)
- 20 Panic Disorder**
 10:30-11:30 A.M.—Christ Hospital, Jersey City
 (Christ Hospital)
- 23 Medical and Psychiatric Aspects of Drug and Alcohol Abuse**
 3-4 P.M.—Ancora Psychiatric Hospital, Hammononton
 (AMNJ)

RADIOLOGY

March

- 10 Scientific Meeting**
 7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
 (New Jersey Institute of Ultrasound in Medicine)
- 16 Dinner Meeting**
 6:30-9:30 P.M.—The Manor, West Orange
 (Radiation Oncology-AMNJ)

SURGERY AND SURGICAL SPECIALTIES

March

- 5 Surgical Treatment of Cardiothoracic Diseases**
 10-11:30 A.M.—New Jersey Medical School, MSB, G-506, Newark
 (UMDNJ)
- 5 Morbidity and Mortality Conference**
12
19 8:30-10 A.M.—New Jersey Medical School, MSB, B-610, Newark
26 (UMDNJ)

MEDICAL SOCIETY OF NEW JERSEY ANNUAL MEETING

Wednesday, April 27, 1988

3:30 p.m.—Board of Trustees' Meeting

Thursday, April 28, 1988

9:00 a.m.—Registration Opens
 9:00 a.m.—Message Center Opens
 1:00 p.m.—Exhibits Open
 2:00 p.m.—House of Delegates
 3:30 p.m.—Reference Committees

Friday, April 29, 1988

8:00 a.m.—Registration Opens
 8:00 a.m.—Message Center Opens
 8:30 a.m.—Exhibits Open
 9:00 a.m.—House of Delegates (election)
 12:00 noon—Golden Merit Award Ceremony followed by Reception
 2:30 p.m.—Reference Committees
 5:00 p.m.—JEMPAC Political Forum
 5:45 p.m.—JEMPAC Wine and Cheese Reception

Saturday, April 30, 1988

8:00 a.m.—Registration Opens
 8:00 a.m.—Message Center Opens
 8:30 a.m.—Exhibits Open
 9:00 a.m.—House of Delegates
 1:30 p.m.—House of Delegates
 6:00 p.m.—Inaugural Reception followed by Inaugural Dinner

Sunday, May 1, 1988

8:00 a.m.—Registration Opens
 8:00 a.m.—Message Center Opens
 8:30 a.m.—Program on one topic of major interest to the physician
 1:00 p.m.—Board of Trustees' Meeting

- 7 Surgical Grand Rounds**
14 4:30-5:30 P.M.—New Jersey Medical
21 School, MSB, B-610, Newark
28 (UMDNJ)
- 9 Vascular Diseases in the Elderly**
 8:30-10 A.M.—Alexian Brothers
 Hospital, Elizabeth
(Alexian Brothers Hospital)
- 16 Surgical Conference**
 11 A.M.—St. Mary Hospital, Hoboken
(St. Mary Hospital)
- 16 Annual Clinical Abstract**
 10:30-11:30 A.M.—Newark Beth
 Israel Medical Center, Newark
(Vascular Society of New Jersey)
- 22 Treatment of Renal Calculi with
 the Lithotripter**
 8-10 P.M.—Englewood Club, 115 E.
 Palisade Avenue, Englewood
(Englewood Surgical Society)
- 30 Ninth Annual Vascular
 Symposium**
 8 A.M.-5 P.M.—New Jersey Medical
 School, MSB, B-552, Newark
(UMDNJ)
- April**
- 2 Surgical Treatment of**
- Cardiothoracic Diseases**
 10-11:30 A.M.—New Jersey Medical
 School, MSB, G-506, Newark
(UMDNJ)
- 2 Morbidity and Mortality**
9 Conference
16 8:30-10 A.M.—New Jersey Medical
23 School, MSB, B-610, Newark
30 *(UMDNJ)*
- 4 Surgical Grand Rounds**
11 4:30-5:30 P.M.—New Jersey Medical
18 School, MSB, B-610, Newark
25 *(UMDNJ)*
- 6 Surgical Procedures for Chronic
 Pancreatitis**
 10:30-11:30 A.M.—St. Mary's
 Hospital, Passaic
(AMNJ)
- 11 Invasive Hemodynamic
 Monitoring**
 7-8 P.M.—Wallkill Valley General
 Hospital, Sussex
(AMNJ)
- 20 Surgical Conference**
 11 A.M.—St. Mary Hospital, Hoboken
(St. Mary Hospital)
- 26 In Vitro Fertilization Update**
 8-10 P.M.—Englewood Club, 115 E.
- Palisade Avenue, Englewood
(Englewood Surgical Society)

UROLOGY

March

- 1 Urology Grand Rounds**
 9 A.M.—Robert Wood Johnson
 Medical School, New Brunswick
(UMDNJ)
- 23 Clinical Cases Presentation**
 6:30-7 P.M.—Robert Wood Johnson
 Medical School, New Brunswick
(UMDNJ)

April

- 1 Urology Grand Rounds**
 9 A.M.—Robert Wood Johnson
 Medical School, New Brunswick
(UMDNJ)
- 27 Clinical Cases Presentation**
 6:30-7 P.M.—Robert Wood Johnson
 Medical School, New Brunswick
(UMDNJ)
- 27 Kidney Stones—Medical
 Approach**
 8:30-10 A.M.—Alexian Brothers
 Hospital, Grassman Hall, Elizabeth
(Alexian Brothers Hospital)

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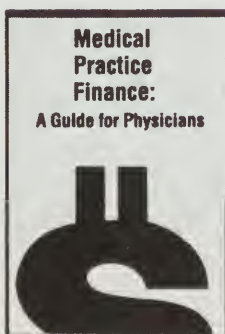
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Levine; Persico**

Dr. Allan S. Ellis

Pathologist Allan Sigismund Ellis, M.D., of New Milford, died on October 24, 1987, at the age of 67. Born in Jamaica, Dr. Ellis attended Meharry Medical College, Nashville, Tennessee, where he received his medical degree in 1951. From 1956 to 1960, he maintained a private practice in Port Leyden, New York, after serving his internship and residency. He was on the staffs of several hospitals, including Wayne General Hospital, where he became chief of pathology and director of laboratory services. Dr. Ellis was a member of our Passaic County component, of the American Medical Association, and of the American College of Clinical Pathologists.

Dr. Paul L. Fabian

A private family practitioner in Trenton for over 45 years, Paul Louis Fabian, M.D., died at the age of 88 on November 28, 1987, at his home in Yardley, Pennsylvania. Born in Shenandoah, Pennsylvania, Dr. Fabian received his medical degree from Hahnemann Medical College, Philadelphia, in 1929, and interned at McKinley Hospital (now known as Helene Fuld Medical Center) in Trenton, later joining its medical staff. Dr. Fabian maintained a private practice on Princeton Avenue, and later at Helene Fuld Medical Arts Building until 1982. In 1964, he was awarded the Helene Fuld Medical Staff Silver Anniversary Award, and was selected Doctor of the Year by the Private Duty Nurses Associa-

tion. Dr. Fabian received MSNJ's Golden Merit Award and Hahnemann Medical College and Hospital's Award for 50 years of distinguished medical practice, in 1979. He was a member of our Mercer County component and of the American Medical Association.

Dr. Philip Levine

The significant contributor to the discovery of the Rh factor, retired hematologist Philip Levine, M.D., passed away on October 18, 1987, at the age of 87, after over 50 years in immunogenetics research and consulting. A native of Russia, Dr. Levine was graduated from Cornell University Medical College, New York, in 1923. He became Director of the Biologic Division at Ortho Research Foundation and was a consultant, specializing in Rh compatibility problems. Dr. Levine served as a visiting investigator at Sloan-Kettering Institute for Cancer Research, New York. He was the recipient of many awards, including: the Mead-Johnson Award (1943), the Lasher Award (1946), the Ward-Burdick Award (1946), the Passano Foundation Award (1958), as well as the MSNJ Golden Merit Award (1973). A Fellow of both the American and Royal Colleges of Physicians, Dr. Levine was a member of our Union County component.

Richard I. Nevin, Sr.

Richard I. Nevin, Sr., Executive Director Emeritus of MSNJ, died on October 28, 1987, at his home in Yardley, Pennsylvania. Born in Jersey City in 1908, he attended Fordham University, New York, where he received his undergraduate degree in premedical studies in 1930. He excelled in both the sciences and the humanities, writing for many university publications and authoring and producing collegiate one-act plays. Aspiring to a career in medicine, he pursued a medical degree for two years at the Long Island College of Medicine, until circumstances brought on by the Depression prohibited him from finishing. In 1931, he became a faculty member of Saint Peter's College, Jersey City, teaching English and speech for the next 20 years. While teaching, Mr. Nevin continued graduate studies in English and speech at Columbia and Fordham Universities. He became the head of the speech

department, and established the College's Bureaus of Public Relations and Placement, becoming the first director of both. Mr. Nevin became coordinator of the postgraduate program in medical studies at Saint Peter's, and because of his growing reputation as a gifted teacher and guest speaker, he was called on to give many courses in speech training to professional groups, including physicians. In 1950, Mr. Nevin was invited to deliver the Elias J. Marsh Oration at the Fall Clinical Conference of the Medical Society of New Jersey, and a year later, he was selected as the Medical Society's Executive Director, serving in that capacity until his retirement in 1973. During the Medical Society's bicentennial year, 1966, Mr. Nevin was elected an honorary member of the Society, and in honor of his many years of assisting and furthering the aim of organized medicine in New Jersey and in national medical affairs, the House of Delegates conferred upon him the life-long title of Executive Director Emeritus, at the 207th Annual Meeting in 1973. Mr. Nevin was a friend, mentor, and advocate for thousands of New Jersey physicians. His distinguished service to this Society is deeply appreciated by his many friends and co-workers.

Dr. Anthony J. Persico

A specialist in orthopedic medicine, Anthony Joseph Persico, M.D., died on October 26, 1987, at the age of 73. A native of New York City, Dr. Persico received his medical degree from Long Island College of Medicine, New York, in 1939. He was a staff surgeon at Bellevue Hospital, New York, from 1951 to 1961, and became affiliated with Holy Name Hospital, Teaneck, where he served as president of the medical staff and chief of the orthopedic service from 1972 to 1975. Since 1954, Dr. Persico operated a private practice in Teaneck. During World War II, he attained the rank of first lieutenant in the medical corps of the United States Army. Dr. Persico was a Diplomate in orthopedic surgery, and a Fellow of the American College of Surgeons; he was a member of our Bergen County component, of the American Medical Association, of the Academy of Orthopedic Surgeons, and of the New Jersey Orthopedic Society.

AUTHOR INFORMATION

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The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable

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2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp 42-48.

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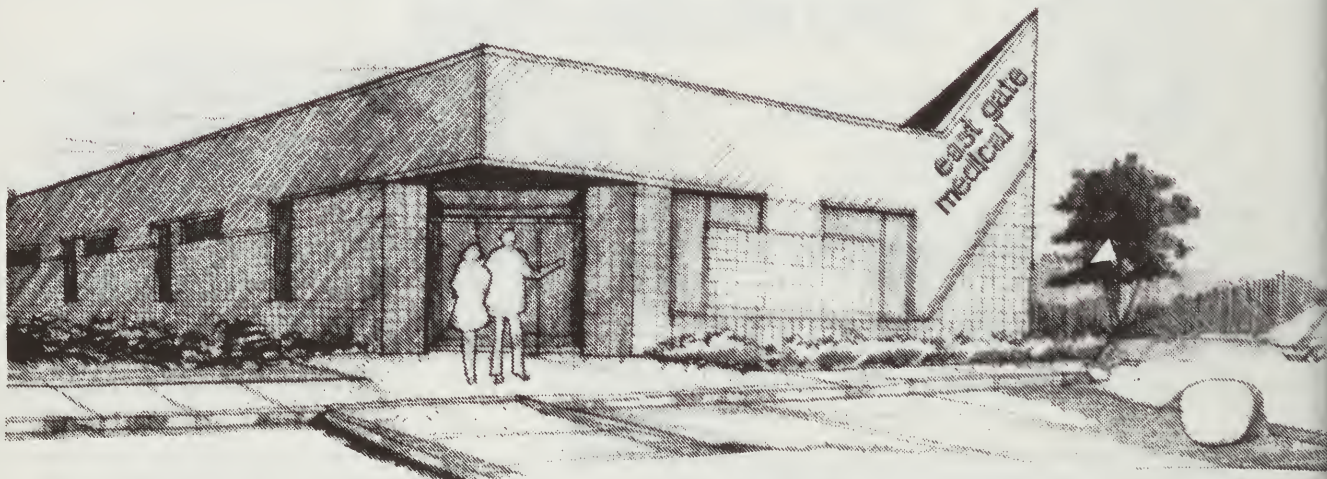
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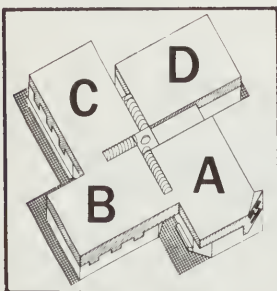


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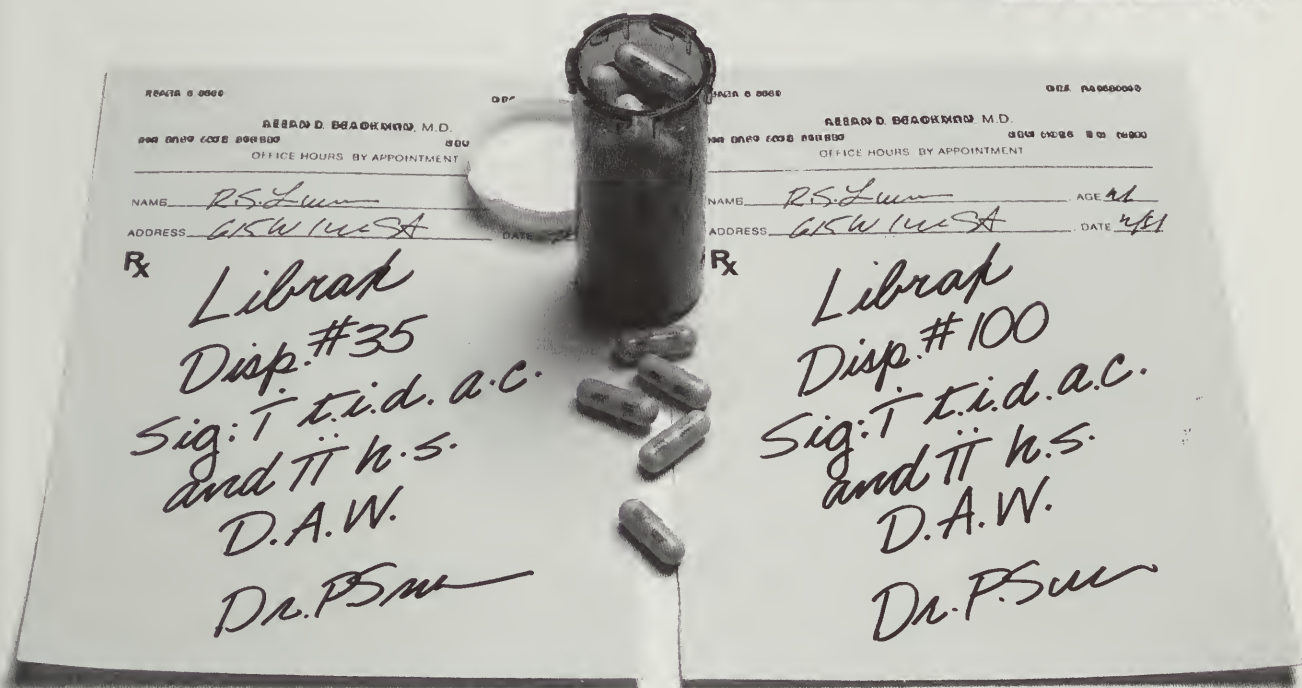
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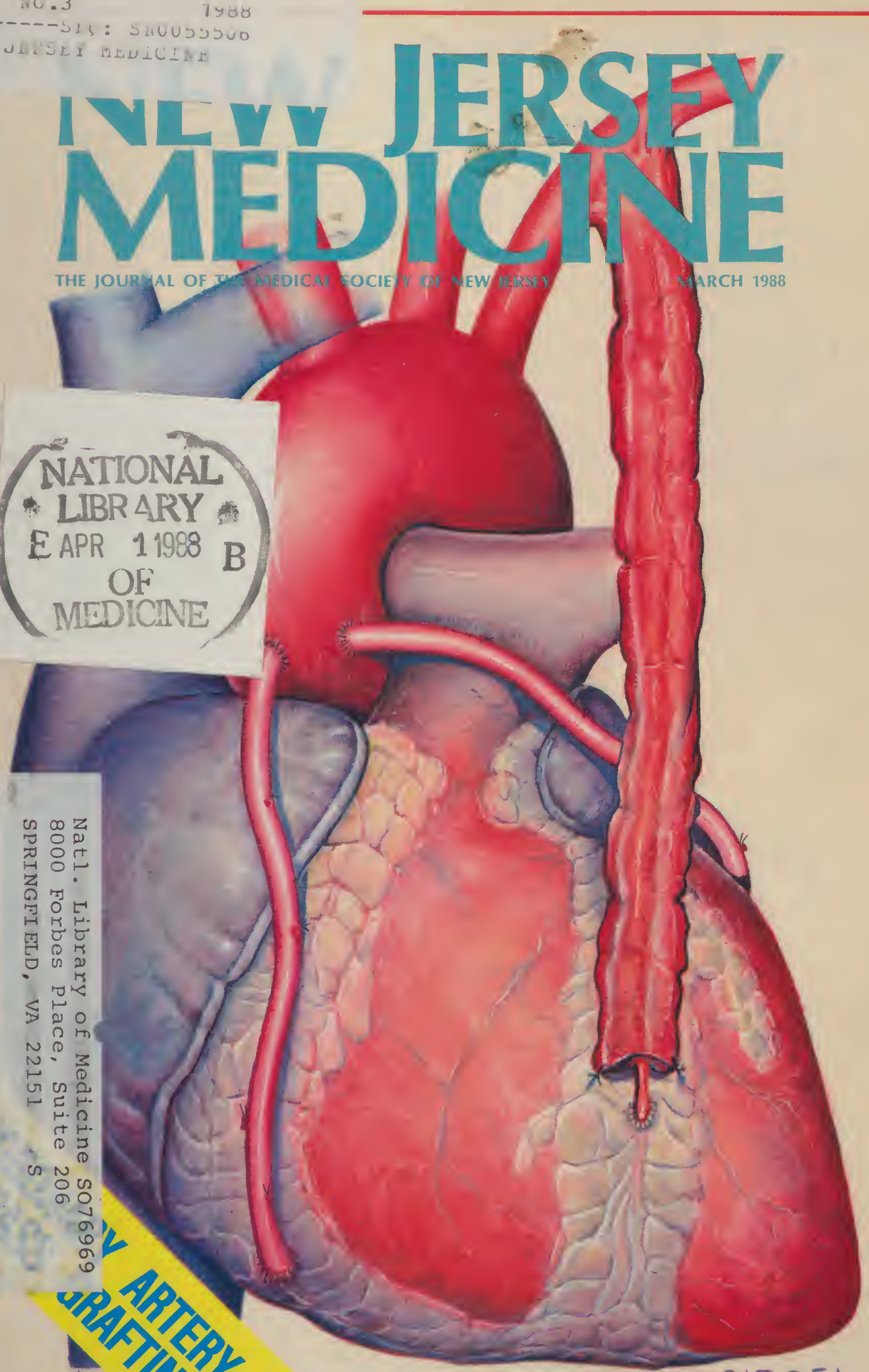
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Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or

without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin[ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The

following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity; purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, stomatitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

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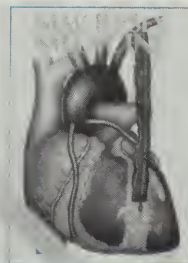
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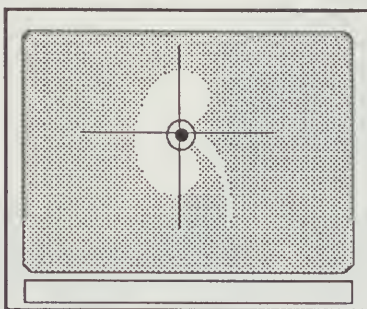
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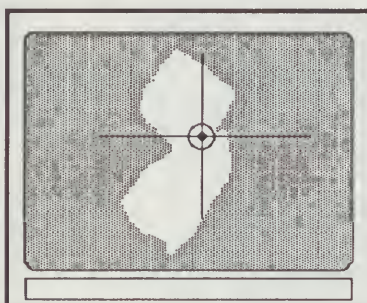
On The Cover: We present a study of patients undergoing coronary artery bypass grafting. The cover shows a heart following coronary bypass grafting. Cover illustration: Stanley H. Siegel.



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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is the drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

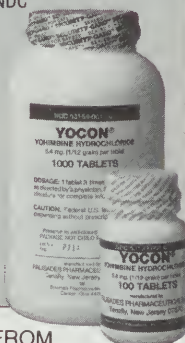
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders; short-term relief of anxiety symptoms, acute alcohol withdrawal symptoms, preoperative apprehension and anxiety. Usually not required for anxiety or tension associated with stress of everyday life. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) reported after abrupt cessation of extended use of excessive doses are similar to those seen with barbiturates. Milder symptoms reported infrequently when continuous therapy is abruptly ended. Avoid abrupt discontinuation; gradually taper dosage.

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Due to isolated reports of exacerbation, use with caution in patients with porphyria.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido — all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. **Oral — Adults:** Mild and moderate anxiety disorders and symptoms, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. **Geriatric patients:** 5 mg b.i.d. to q.i.d. (See Precautions.)

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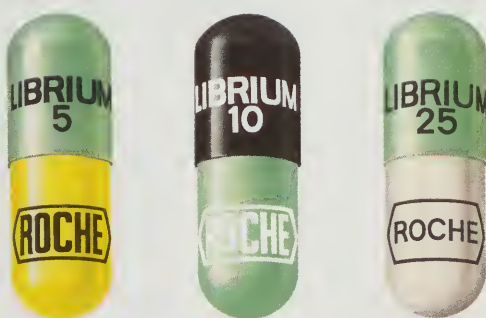
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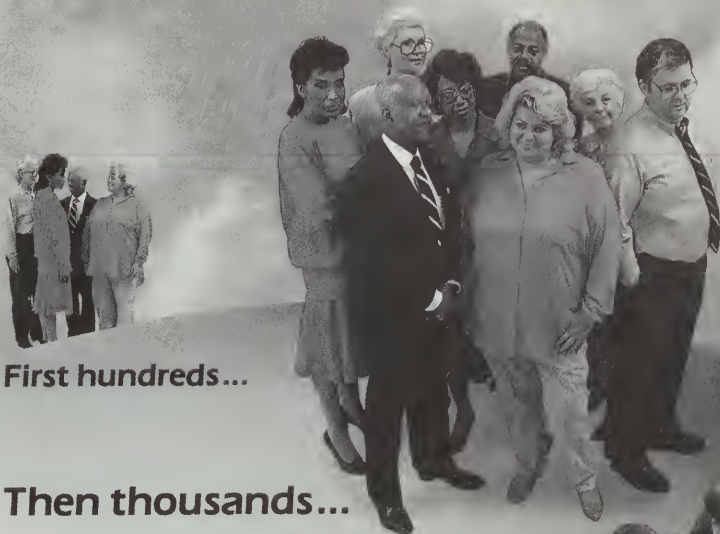
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Any change of insulin should be made cautiously and only under medical supervision. Changes in refinement, purity, strength, brand (manufacturer), type (regular, NPH, Lente®, etc), species/source (beef, pork, beef-pork, or human), and/or method of manufacture (recombinant DNA versus animal-source insulin) may result in the need for a change in dosage.

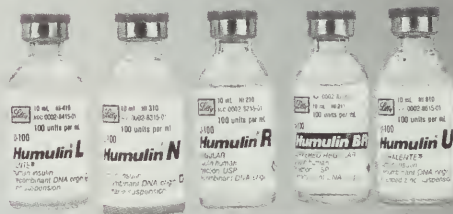
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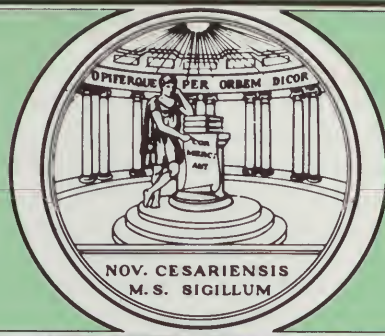
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MEMBERSHIP NEWSLETTER



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THE MEDICAL SOCIETY OF NEW JERSEY

VOLUME 52

HEALTHSTART

HealthStart is a major, new state initiative to improve the accessibility and scope of maternal and child health services available in New Jersey to all Medicaid pregnant women and children under the age of two. The program started in February 1988.

HealthStart is a joint program of the Department of Human Services and Department of Health. All HealthStart providers must be Medicaid providers; however, not all Medicaid providers will be HealthStart providers. All HealthStart providers will be required to hold a Certificate, issued by the Department of Health, verifying the provider's ability to deliver the required, comprehensive HealthStart services.

The major features of HealthStart are: an enriched package of maternity and preventive pediatric services for Medicaid pregnant women and children under the age of two; major consumer outreach efforts at the state and community level; increased reimbursement to providers; continuing education services for providers; and ongoing quality assurance and outcome measure activities.

Clients who are receiving HealthStart services are entitled to receive the full range of Medicaid services.

Who is eligible for HealthStart: all Medicaid eligible pregnant women including those pregnant women determined presumptively eligible; and all Medicaid children under two years of age.

HealthStart Maternity Care. *Eligible Providers:* The following Medicaid providers are eligible to apply for a HealthStart Maternity Care Certificate: ambulatory care centers, including independent clinics and hospital-affiliated clinics; physicians and physician groups; certified nurse midwives. Applications for Maternity Care Certificates are available from HealthStart, New Jersey Department of Health.

Comprehensive Services: The comprehensive service package has two major components: medical services and health support services. Both the medical care and health support services are expected to be provided at one contiguous site. Private practitioners are permitted to use two sites if the delivery of comprehensive services is not feasible at one site. HealthStart Providers are encouraged to directly provide both components of the enriched service package but are permitted to make an arrangement with another HealthStart maternity care provider for the delivery of medical services or health support services. Service agreements must specify which provider is assuming

primary care coordination responsibility for the patient.

HealthStart medical services include prenatal visits, intrapartum care, and postpartum visits as recommended by the American College of Obstetricians and Gynecologists.

Health Support Services include case coordination and followup services, social/psychological assessment guidance and counseling, nutrition assessment, guidance and counseling, home visitation, health education instruction, and referral to and followup with other community-based service providers.

Pediatric Care. *Eligible Providers:* The following Medicaid providers are eligible to apply for a HealthStart Pediatric Care Certificate: ambulatory care centers, including independent clinics and hospital affiliated clinics; physicians and physician groups. Applications for Pediatric Care Certificates are available from the New Jersey Department of Health.

Comprehensive Services: HealthStart Pediatric services are designed to assure that each child receives coordinated preventive health care and sick care.

All HealthStart providers who are eligible to provide Early Periodic Screening, Diagnosis and Treatment (EPSDT) services are required to provide such services.

Pediatric services include: nine preventive child health visits in accordance with the standards of the American Academy of Pediatrics; immunizations; outreach and followup for missed appointments; provision or arrangement for sick care and 24-hour telephone coverage; and appropriate follow-up.

MSNJ ANNUAL MEETING

The 222nd Annual Meeting of the Medical Society of New Jersey will open on Thursday, April 28, 1988, at the Sheraton Meadowlands Hotel in East Rutherford.

Registration for the Annual Meeting begins at 9 A.M. on Thursday and at 8 A.M. for the next three days. In addition to the Message Center which is in operation throughout the Annual Meeting, there will be an exhibit hall open to registrants and guests.

The House of Delegates commences on Thursday at 2 P.M.; elections are held on Friday, April 29, 1988, at 9 A.M. Also, on Friday is the Golden Merit Award ceremony honoring physicians who have been in practice for 50 years in New Jersey. After Reference Committee meetings in the afternoon, JEMPAC, the state medical political action committee, will host a political forum

PRESIDENT'S HOTLINE: HARRY M. CARNES, M.D.

★ **Malpractice Surcharge Opposed.** The Society has advised Commissioner Merin of the State Department of Insurance that it is opposed to his plan to levy an across-the-board surcharge on all currently insured physicians to finance a deficit of \$60 million. The deficit relates to the Malpractice Reinsurance Association, activated by Commissioner Sheeran in 1977 and operated through 1982. The Board maintains that only those physicians who were insured through that entity should be surcharged to fund the deficit that their experience created. Legal action will be instituted by the Medical Inter-Insurance Exchange and the Society if the Commissioner pursues his "across-the-board" plan.

★ **AIDS Task Force.** The AIDS Task Force met on January 27, 1988, to recommend testing policy to MSNJ and give guidance to our legislative stance on various bills that have been introduced. A statewide AIDS educational program will be announced shortly in conjunction with the Academy of Medicine of New Jersey. The Task Force will develop a program for our Annual Meeting, to be presented on Sunday, May 1, 1988.

★ **Membership.** Medicine faces some of its most difficult struggles in the next several years. Doctor "bashers" are everywhere. We must consolidate. We must maximize our potential. Every member should seek to recruit one new member per year.

at 5 P.M. and a wine and cheese reception at 5:45 P.M.

The House of Delegates holds two sessions on Saturday, and the day closes with the inaugural reception and dinner honoring Palma Formica, M.D.

One Sunday, May 1, 1988, at 8:30 A.M., there will be a educational program on an topic of major interest to all physicians.

Your attendance at the Annual Meeting will ensure an active Medical Society. For further information, please call MSNJ Headquarters at 609/896-1766.

NOTIFICATION OF DUES NONDEDUCTIBILITY

The recently enacted tax legislation requires all exempt organizations, other than those exempt under Section 501(c)(3) of the Internal Revenue Code, to include in "each fundraising solicitation" made after January 31, 1988, "an express statement (in a conspicuous and easily recognizable format) that contributions or gifts to such organizations are not deductible as charitable contributions for federal income tax purposes." This requirement is applicable to all solicitations in written form, by television or radio, or by telephone. The only statutory exceptions are for small organizations whose gross receipts are normally not more than \$100,000 per year and a solicitation by letter or telephone which is "not part of a coordinated fundraising campaign soliciting more than 10 persons during the calendar year."

Failure to comply with this requirement can result in severe penalties. In general, failure to comply will result in a penalty of \$1,000 for each day on which the failure to comply occurred, to a maximum of \$10,000 a year for each organization. This penalty is not imposed if the failure to comply was due to "reasonable cause." What constitutes reasonable cause for not complying is not clear. If, however, the failure is due to an intentional disregard of the requirement, the \$10,000 maximum does not apply and the penalty for each day is the greater of \$1,000 or 50 percent of the cost of the solicitations made on that day. For purposes of these penalties, the failure to comply is deemed to occur only on days the solicitation is actually made, e.g., when a solicitation is mailed or phone calls are made.

In order to comply with this requirement, it will be necessary to include a statement regarding nondeductibility on all solicitations for medical association dues and PAC contributions. The following wording

has been suggested: Contributions to AMPAC and State PAC are not deductible as charitable contributions for federal income tax purposes.

Due to the immediacy of this provision, it is imperative that this be done as quickly as possible to avoid any monetary penalties.

PSYCHIATRIC REFERRAL/RESOLUTION

The following resolution was adopted by the Board of Trustees at its December 1987 meeting:

Resolved, that the Medical Society of New Jersey encourages its members to consult with a psychiatrist for patient evaluation, assessment, and recommendations before referring such patients to nonmedical mental health professionals for the treatment of mental illness.

SPECIAL COUNSEL TO MSNJ

Herbert J. Stern, who won national recognition as United States District Court Judge and as United States Attorney for New Jersey, will serve as special counsel to the Medical Society of New Jersey to review procedures for identifying and treating impaired physicians while protecting the public.

"The State Commission of Investigation (SCI) has raised serious questions about New Jersey law governing physicians and other health care providers and about procedures of the Board of Medical Examiners," said MSNJ President Harry M. Carnes, M.D. "Left unanswered, the report could undermine the public's confidence in their physicians and other health care professionals. We agree that existing laws and regulatory procedures can be improved. Such improvements must be based on a full airing of the facts. We're delighted that Judge Stern will work with us, the legislature, and the SCI in developing such an exposition of the facts."

"We intend to work in a constructive way with the Legislature, the SCI, and the Board of Medical Examiners," Stern said. "The Medical Society's procedures for treating impaired physicians and reporting to the authorities those who are incompetent to practice medicine are recognized as the national model for the protection of the public. While there's always room for improvement, we want to assure that the benefits of MSNJ's widely recognized program are not needlessly lost."

ATTENDANCE AT BOARD OF TRUSTEES' MEETINGS:
County and Specialty Societies, Academy of Medicine of New Jersey, and MSNJ Auxiliary
 July 1987-December 1987

Atlantic County

July 19 Howard Slotoroff, M.D., Secretary

Bergen County

September 20 Matis A. Fermaglich, M.D.

Burlington County

July 19 Stanley R. Lane, M.D.

December 20 Charles J. Moloney, M.D.

Irving P. Ratner, M.D.

Camden County

July 19 Emmons G. Paine, M.D.

September 20 Frederick W. Durham, M.D.

Mrs. Ardith R. Lane, Executive
Director

Joseph A. Riggs, M.D.

November 15 Frederick W. Durham, M.D.

Mrs. Ardith R. Lane, Executive
Director

Joseph A. Riggs, M.D.

December 20 Frederick W. Durham, M.D.

Mrs. Ardith R. Lane, Executive
Director

Joseph A. Riggs, M.D.

Cumberland County

September 20 Gerald S. Packman, M.D., President

Essex County

December 20 George J. Hill, M.D.

Harvey P. Yeager, M.D.

Gloucester County

September 20 Churchill L. Blakey, M.D.

November 15 Churchill L. Blakey, M.D.

December 20 Churchill L. Blakey, M.D.

Hudson County

July 19 Charles L. Cuniff, M.D.

Francis A. Deitmaring, M.D.,
Past President

Frank J. Primich, M.D.

November 15 Charles L. Cuniff, M.D.

Frank J. Primich, M.D.

December 20 Charles L. Cuniff, M.D.

Mercer County

July 19 Mrs. Joey Huddy, Executive
Secretary

September 20 Mrs. Linda L. McGhee

November 15 Mrs. Joey Huddy, Executive
Secretary

Manuel A. Rivas, M.D.,
President-Elect

December 20 Mrs. Joey Huddy, Executive
Secretary

Mrs. Linda L. McGhee
Robert L. Pickens, M.D.

Manuel A. Rivas, M.D.,
President-Elect

Middlesex County

July 19 Mrs. Mary Alice Bruno, Executive
Director

John D. Slade, M.D.

November 15 Mrs. Mary Alice Bruno, Executive
Director

Leticia V. DeCastro, M.D.,
President-Elect

December 20 Mrs. Mary Alice Bruno, Executive
Director

Timothy M. Hosea, M.D.

John D. Slade, M.D.

Monmouth County

July 19 Mrs. Patricia Klemm, Executive
Secretary

September 20 Natalio Damien, M.D., President

Mrs. Patricia Klemm, Executive
Secretary

December 20 Natalio Damien, M.D., President

Morris County

September 20 William J. Dowling, Jr., M.D.

November 15 Martin L. Cohen, M.D.,
President-Elect

December 20 Daniel J. Schwartz, M.D.

Ocean County

July 19 Ira J. Holzman, M.D., Assistant to
President

David M. MacPeck, M.D.

September 20 Miss Nanette Stummer, Executive
Director

November 15 Herbert J. McBride, M.D.
Miss Nanette Stummer, Executive
Director

December 20 Miss Nanette Stummer, Executive
Director

Passaic County

July 19 Elmar G. Lutz, M.D., President

September 20 Philip J. Jasper, M.D., Vice-President

November 15 Elmar G. Lutz, M.D., President

December 20 Elmar G. Lutz, M.D., President

Sussex County

September 20 Ronald K. Harris, M.D., President

November 15 Ronald K. Harris, M.D., President

Union County

July 19 A. Ralph Kristeller, M.D.
Ms. Irene Rosenthal, Executive
Director

September 20 A. Ralph Kristeller, M.D.
Frank R. Romano, Sr., M.D.
Ms. Irene Rosenthal, Executive
Director

November 15 A. Ralph Kristeller, M.D.
Frank R. Romano, Sr., M.D.
Ms. Irene Rosenthal, Executive
Director

December 20 A. Ralph Kristeller, M.D.
Frank R. Romano, Sr., M.D.
Ms. Irene Rosenthal, Executive
Director
Robert L. Wegryn, M.D., President

ATTENDANCE AT BOARD OF TRUSTEES' MEETINGS:
County and Specialty Societies, Academy of Medicine of New Jersey, and MSNJ Auxiliary
 July 1987-December 1987

Warren County

July 19 James H. Spillane, M.D.
 September 20 Robert Emery, M.D., Past-President
 James H. Spillane, M.D.
 November 15 James H. Spillane, M.D.
 December 20 James H. Spillane, M.D.

New Jersey State Society of Anesthesiologists

July 19 Stanley Bresticker, M.D.
 September 20 Stanley Bresticker, M.D.
 H. Lawrence Karasic, M.D., President
 November 15 Stanley Bresticker, M.D.

**New Jersey Chapter, American College of
 Emergency Physicians**

July 19 Rudolf E. Schwaeble, M.D.
 September 20 Rudolf E. Schwaeble, M.D.
 November 15 Rudolf E. Schwaeble, M.D.
 December 20 Rudolf E. Schwaeble, M.D.

New Jersey Academy of Family Physicians

September 20 John C. Brogan, M.D., President

New Jersey Society of Internal Medicine

July 19 Huerta C. Neals, M.D., President
 September 20 Frank J. Malta, M.D.
 November 15 Frank J. Malta, M.D.
 December 20 Huerta C. Neals, M.D., President

**New Jersey Association of Medical
 Specialty Societies**

July 19 Stanley Bresticker, M.D.
 September 20 Stanley Bresticker, M.D.
 November 15 Stanley Bresticker, M.D.

New Jersey Neurosurgical Society

November 15 Ira Kasoff, M.D., President-Elect

**American College of Obstetricians and
 Gynecologists, New Jersey Section**

September 20 John S. Garra, M.D., Chairman

New Jersey Obstetrical and Gynecological Society

September 20 John D. Franzoni, M.D.
 December 20 John D. Franzoni, M.D.
 Gilbert R. Sugarman, M.D.,
 President

New Jersey Society of Pathologists

September 20 Frank Campo, M.D., President

November 15 Frank Campo, M.D., President
 December 20 Frank Campo, M.D., President

New Jersey Psychiatric Association

July 19 John C. Patterson, M.D., Liaison
 September 20 John C. Patterson, M.D., Liaison
 December 20 Eva Muller, M.D., President-Elect
 John C. Patterson, M.D., Liaison

New Jersey Rheumatism Association

July 19 William E. Ryan, M.D., Liaison
 September 20 William E. Ryan, M.D., Liaison
 November 15 William E. Ryan, M.D., Liaison
 December 20 William E. Ryan, M.D., Liaison

American College of Surgeons, New Jersey Chapter

November 15 Roy A. Morrow, M.D., President

The Society of Surgeons of New Jersey

December 20 Elmer L. Grimes, M.D.

Urologic Society of New Jersey

July 19 Arthur Ginsburg, M.D., President

Academy of Medicine of New Jersey

July 19 Mr. Charles J. Heitzmann, Executive
 Director
 September 20 Sherman Garrison, M.D.
 Mr. Charles J. Heitzmann, Executive
 Director
 November 15 Ronnie Davidson, Ed.D., Associate
 Director
 Sherman Garrison, M.D.
 Mr. Charles J. Heitzmann, Executive
 Director
 December 20 Ronnie Davidson, Ed.D., Associate
 Director
 Sherman Garrison, M.D.
 Mr. Charles J. Heitzmann, Executive
 Director

Medical Society of New Jersey Auxiliary

July 19 Mrs. Leonardo Ilagan, President
 September 20 Mrs. Leonardo Ilagan, President
 November 15 Mrs. Leonardo Ilagan, President
 December 20 Mrs. Frank Campo, President-Elect
 Mrs. Bernardine N. Moloney,
 Fellowette

LEGISLATIVE AND REGULATORY NOTES

1. Congress and the Administration Reach Economic Agreement. Following a month of intense and divisive negotiations, congressional leaders and President Reagan concluded the "other" Washington summit by announcing agreement on the outlines of a spending and tax package. This package, designed to provide for two years of deficit reduction, would putatively reduce the deficit by \$76 billion over two years. The agreement specifically provides for \$30 billion in reductions for fiscal year 1988 and \$45.5 billion for fiscal year 1989. However, the plan provides only a broad sketch of the necessary combination of

spending reductions and revenue increases needed to meet the outlined goals. Indeed, as part of the agreement, the Senate must pass a reconciliation bill following the return of Congress from its Thanksgiving recess. Following this action, conferees will be appointed from both the House and Senate to negotiate a compromise agreement. Any such agreement would then be wrapped up either as part of or to accompany the Continuing Resolution for appropriated funds needed for the remainder of fiscal year 1988. The current resolution providing for government operations expired December 16, 1987. Under the "summit" agreement, the Medicare program would absorb cuts from current policy of \$2.0 billion in fiscal year 1988 and \$3.5 billion

in fiscal year 1989. It is likely the additional cuts from Medicare will build on the \$1.5 billion in reductions previously identified in the congressional budget resolution and provided for under the reconciliation bill passed by the House in September 1987. Congressional sources indicate that the additional Medicare reductions could come from cuts of up to \$125 million from physician providers, \$180 million from hospitals, \$180 million from laboratory fees, and the balance from reductions in payments for durable medical equipment. Reliable sources indicate that the most politically feasible source for reductions in physicians' payments would be through a partial or total freeze on the physician update under Part B. As part of such a freeze, beneficiary "protections" through modifications to the MAAC (maximum allowable actual costs) program could be employed. It is not yet clear how agreed-upon reductions for fiscal year 1989 would be guaranteed and enforced. While the architects of the congressional-administrative "summit" agreement are optimistic as to its prospects, other sources indicate that final agreement on any such passage is questionable. Many congressional Republicans and conservative Democrats may be willing to rely on the existing \$23 billion in Gramm/Rudman/Hollings automatic reductions instead. For these members, the Gramm-Rudman cuts are real. (For Medicare, this would mean a 2.34 percent reduction in reimbursements.) Since the so-called "sequester" already has taken place, Congress may give up the effort to flesh out the skeleton of the agreement reached by the month-long "summit."

2. AMA Concerns Lead To Changes in MAAC Monitoring. The Health Care Financing Administration (HCFA) has made important modifications in the MAAC monitoring process in response to AMA concerns about past problems in implementing the MAAC limits. HCFA delayed issuing violation notices to be sure that carriers properly carried out their instructions. AMA objected that too little time was to be given to physicians to adjust their charges in cases of alleged violations. Consequently, except in extreme situations, physicians will not be referred to the Inspector General for sanctions if they reduce their charges to a level at or below the MAAC limit. In addition, HCFA raised the cumulative threshold to trigger a violation notice from \$500 to \$700. For example, if a charge is \$50 above the MAAC limit and the service is provided 14 times, a violation notice would be issued. In cases where physicians received inaccurate MAAC data from the carrier, monitoring is to begin after the date of the corrected or recalculated MAAC. Even with the above modifications, approximately 5 percent of non-participating physicians nationwide are expected to receive MAAC warning letters. Physicians should immediately respond, in writing, if a potential violation notice is received. If the local Medicare carrier fails to respond to your inquiry, promptly contact the Regional HCFA Office.

3. Washington Legislative Summary.

Clearinghouse. Concerted AMA lobbying on both the federal and congressional fronts achieved a major victory with House and Senate passage of S. 1158. This bill includes provisions absolutely essential to physicians. It would effectively amend the Health Care Quality Improvement Act of 1986 to eliminate broad access

by malpractice attorneys to physician data bank information. The bill now goes for signature to President Reagan who opposed the bill by waging a final all-out attempt to defeat the measure.

Drug Dispensing. The strength of AMA contacts both in Washington and from the Federation has kept the Wyden prescription drug dispensing bill from reaching the House floor. The bill now appears dead for the remainder of this congressional session.

Tobacco. Building on AMA focus on the ill-health consequences of tobacco smoking, both the House and Senate are in conference on a bill that would ban smoking on most domestic airline flights. AMA continues to keep up the pressure on this key health issue and appears headed for a major "win."

Professional Liability Insurance. AMA-sponsored bills to resolve the medical malpractice insurance crisis continue to serve as the focal point for congressional debate. In discussions with the major congressional players in this area, AMA input and support is viewed as critical to moving the legislation. AMA will continue seeking a workable federal solution in this area through its leadership role.

Catastrophic Medicare Coverage. Both the House and Senate have passed bills to protect the nation's elderly from catastrophic medical expenses. Through persistent AMA efforts, the Senate version explicitly prohibits a drug formulary. AMA will redouble its efforts with House and Senate conferees to ensure that no formulary or similar provision is added.

UBIT. Although the House-passed reconciliation bill contains a provision that would tax the investment income of 501(c)(6) professional and trade associations, AMA continues its efforts to keep the provision from becoming law. In a recent letter to Senate Finance Committee Chairman Bentsen, over 20 Senators joined in opposing the provision. With the help of the Federation, we hope to stop the UBIT provision from being enacted into law.

PROs. Thanks in large measure to the unyielding demands of the AMA, the House and the Senate Finance Committee passed reconciliation bills containing language essential to physicians involved in peer review. Chief among the victories on this front was significant added due process protection for physicians. AMA will continue the fight to retain these provisions in the budget summit reconciliation process.

MEDICARE BUDGET RECONCILIATION

A. Provisions Relating To Medicare Part B.

1. Physician Reimbursement Update. The 2.34 percent reduction in reimbursement for services provided on or after November 21, 1987, under Gramm-Rudman sequestration will continue for services provided through March 31, 1988, for all physicians regardless of participation status.

Beginning April 1, there will be four different levels of reimbursement increases depending on the physician's participation status and the type of service. For participating physicians, there will be a 3.6 percent increase for primary care services and a 1 percent increase for nonprimary care services. For nonparticipating physicians, there will be a 3.1 percent increase for primary care services and a 0.5 percent increase for

nonprimary care services. There will be incentive payments for primary care services furnished by physicians in rural areas or in a health manpower shortage area.

2. *Inherent Reasonableness.* Reimbursement for 15 procedures will be reduced by 2 percent nationwide (though no level of reimbursement will be allowed to drop below 85 percent of the national average) beginning April 1, 1988. There will be further cuts (up to 15 percent) for these services depending on how the prevailing charge for the service in an area relates to the national average prevailing charge for that service. A full 15 percent will be taken for services where the area prevailing charge is greater than 150 percent of the national prevailing charge with reduced levels of reduction for charges between 150 percent and 100 percent of the national average.

The following are the procedures for which reductions are made: coronary artery bypass surgery; total hip replacement; cataract surgery; transurethral prostatectomy; suprapubic prostatectomy; diagnostic and/or therapeutic dilatation and curettage; carpal tunnel neurolysis and/or transposition; pacemaker surgery; bronchoscopy; upper gastrointestinal endoscopy; and knee arthroscopy and knee arthroplasty.

Medicare reimbursement for ophthalmic ultrasound procedures will be limited to 5 percent of the prevailing charge for cataract surgery with intraocular lens implantation.

3. *New Physicians.* The customary charge for new physicians will be set at 80 percent of the prevailing charge. This provision does not apply to primary care services or to services furnished in rural health manpower shortage areas. For these services, current law will be followed with the customary charge profile set at the 50th percentile of customary charges.

4. *Anesthesiology Special Limits.* Payments for concurrent supervision of certified registered nurse anesthetists will be reduced.

5. *Radiology Fee Schedule.* A fee schedule will be established for radiology services provided by board-certified and board-eligible radiologists or by physicians whose charges for the radiologic service account for 50 percent or more of their Medicare billings. There will be special fee controls on those procedures.

6. *Clinical Laboratory Services.* The 2 percent differential in payment between hospital outpatient labs and independent clinical labs (except for sole community hospitals) will be eliminated. Prevailing charges for automated tests and tests subject to the lowest charge provisions (except cytopathology) will be reduced. Other provisions revise the calculation for payment ceiling, establish intermediate sanctions for labs which no longer substantially meet the conditions for participation for clinical labs, and provides for treatment of high volume physician office labs as independent clinical labs.

7. *Durable Medical Equipment.* There will be a one-year freeze on durable medical equipment payment screens effective January 1, 1988, at levels in effect December 31, 1987.

8. *Radiology Services in Hospital Outpatient Departments.* There will be a limit on aggregate payments for hospital outpatient radiology departments.

9. *Ambulatory Surgery.* Beneficiary cost sharing for

physician services provided in ambulatory surgical centers is reinstituted.

Part B Premium. The Part B premium will continue to provide 25 percent of program costs through calendar year 1989.

Mental Health Services. The maximum payment for outpatient mental health services will increase to \$450 in 1988 and \$1,100 in 1989.

Peer Review Organizations. Numerous changes have been made concerning peer review organizations. A provider or practitioner excluded from the Medicare program by a PRO will be entitled to a hearing before an administrative law judge prior to the effectiveness of the exclusion. PRO contracts will be authorized for three year periods with staggered expiration dates. PROs will be prohibited from publicizing payment denials without first offering the provider or practitioner prior notification and opportunity for discussion. In establishing review standards, PROs will be required to take into account the special problems associated with delivering care in remote rural areas, the availability of service alternatives to inpatient hospitalization, and social factors that could adversely affect safety and effectiveness of outpatient treatment. PROs will be required to perform substantial on-site review in 20 percent of the rural hospitals in the PRO's area. PROs will be required to meet several times each year with hospital medical and administrative staff about PRO review.

B. Provisions Relating to Part A and Part B.

1. *Payment Delays.* Claims will be held for ten days after the date of receipt during the last three months of fiscal year 1988 (July, August, and September 1988) and for 14 days during fiscal year 1989.

IRA: YOUR RETIREMENT NEST EGG

When the Tax Bill of 1986 went into effect, tens of thousands of individuals sent up a collective groan as they saw their annual \$2,000 individual retirement account (IRA) contribution lose its eligibility as a tax deduction.

At first glance, many of us perceived this to be the end of the IRA—after all, the "tax shelter aspect" was the only benefit of an IRA in the first place, wasn't it? Or was it?

But, where IRAs are concerned, our legislators didn't eliminate all the benefits to investors.

For it quickly became apparent, even for those who were ineligible to deduct the IRA contribution annually (and that certainly includes many in the medical profession), there still is one impressive rationale for establishing and contributing to an IRA investment—the tax-free compounding of earnings.

And, make no mistake about it, over time, whether one has 30, 20, 10, or 5 years to accumulate an IRA retirement investment, it makes overwhelming sense—dollars and sense—to do so.

With this as a given, those of you who have an IRA should continue it; those of you who haven't yet established an IRA should consider it a good first retirement planning step to take. Begin it early and contribute regularly.

When you have an IRA as part of your overall retirement package, you'll soon find that tax-deferred compounding in your IRA is a powerful lure.

As long as you have an IRA working for you, you will enjoy tax-deferred earnings while building your financial security. There are no federal income taxes to pay until you start to withdraw the money—as early as age 59½, if you so choose. (If you withdraw any portion of your money before age 59½, there is a 10 percent penalty and taxes to be dealt with.)

Now, what does tax-free compounding of your earnings mean to you?

The accompanying chart dramatically illustrates the value of your IRA's tax-deferred advantage amounting to over \$75,000 of additional earnings versus an identical investment without tax-deferred compounding. The accumulated amounts are based on a \$2,000 annual contribution over a 25-year period, earnings at the annual rate of 10 percent and a 28 percent tax bracket.

But the big question still keeps cropping up: Is it worth investing in an IRA if you cannot deduct the annual contribution?

As you can see, the benefits of tax-deferred compounding allows your money to grow at a much faster rate than if it were in a taxable account, and that's a big plus.

Invest your IRA dollars early in the year in order to take full advantage of tax deferred earnings on your account. If you haven't made your 1987 contribution yet, you have until April 15, 1988, to do so. By doing it now and contributing another \$2,000 for 1988 at the same time, you will optimize the tax-free compounding of your money.

Also, putting \$2,000 into an IRA each year is a good saving discipline and adds up quickly towards your retirement income.

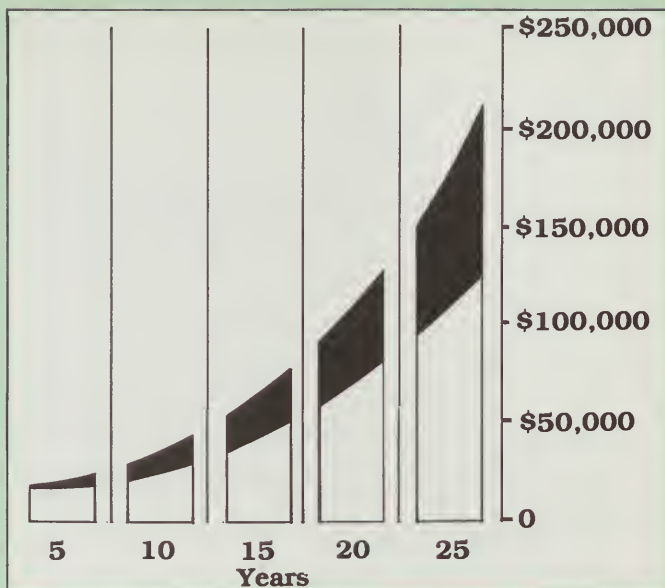
Where to Invest. Naturally, choosing the right types of investments for your Individual Retirement Account is important. Diversification has always been a sound investment strategy. Your IRA assets should be spread among several investments in order to reduce your investment risk in the volatile financial world.

Towards this end, mutual funds provide diversification, are quite compatible with the long-term objectives of your IRA, and offer a number of additional benefits. These include a wide range of objectives, the ability to switch among funds, professional management, liquidity, and easy recordkeeping.

Another point to consider: some mutual funds are offered at net asset value and do not charge a load (a commission). Eliminating the load means 100 percent of your IRA contribution works for you from Day One and that can add up to substantially more retirement dollars for you.

Of course, how you allocate your IRA investments depends on your own personal circumstances—your age, current tax status, income, objectives, the right combination of safety and risk, as well as consideration of your other retirement assets. Any of these may change along the way (including your financial responsibilities—i.e. getting married, having children, college costs, caring for a parent) making it important to keep an eye on your investment mix and altering it accordingly.

Estimate your retirement needs as best you can and make sure you will have enough money to retire comfortably.



If your money is growing according to your expectations and your asset allocation remains appropriate, your portfolio is working well. If not, make some changes and monitor your IRA until you are satisfied with its success rate.

Remember that whatever your circumstances and even though tax reform has limited the deductions on contributions, Individual Retirement Accounts still make sense as a long-range benefit in building and enhancing your retirement nest egg—and if you select properly, that egg may turn out to be golden!

—AMA Advisers

SOCIETY OF ASSOCIATION EXECUTIVES



Joseph C. Lucci, Director of Medical and Insurance Affairs for MSNJ is the new president of the New Jersey Society of Association Executives. Lucci, a native of Trenton, has been a member of the Association since 1973; the group represents the professional staff of the trade and professional associations headquartered in New Jersey. As Director of Medical and Insurance Affairs for the Medical

Society of New Jersey, Lucci is the liaison for third-party payers and all members; he oversees 17 committees for the Society dealing with membership services.

RENTAL CAR DEDUCTIBLE

The Gold Mastercard endorsed by the Medical Society of New Jersey has added a new feature: the rental car deductible reimbursement. Each time you charge a rental car to your credit card you will receive coverage for up to \$3,000 of your deductible for collision damage covered by your own or the rental company's insurance at no additional cost. If your insurance does not cover auto rental collision, a benefit of up to \$3,000 will be paid. To apply for your Gold Mastercard call 1-800-847-7378.

FINI

"Man's greatness does not lie in perfection, but in striving for it."

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**222nd ANNUAL MEETING
MEDICAL SOCIETY OF NEW JERSEY
Thursday, April 28, to Sunday, May 1, 1988**

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DEPARTURE DATE _____ DAY _____

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Tel: (201) 896-0500

Reservations must be received by April 6, 1988. Those received after cutoff date will be accepted on a space available basis only.

LEGISLATIVE REPORT: CLARK MARTIN, MSNJ LEGISLATIVE CONSULTANT

MEDICAID UPDATE

A two-pronged effort to move primary health care for the poor out of the hospital emergency room and back to the physician's office was detailed by Gov. Kean in his annual budget message to the Legislature.

The plan calls for increasing Medicaid rates for office visits while at the same time forming a Medicaid HMO called the Garden State Health Plan.

Human Services Commissioner Drew Altman, meeting with the Society's Medicaid Committee, said that reorganizing the \$1.6 billion program is his Department's top priority for the 1988-89 fiscal year.

Admitting that too many of the State's poor depend on expensive hospital emergency rooms and clinics for primary care and that too few physicians and other providers now participate in the program—the residue of 15 years' of frozen reimbursement rates—Commissioner Altman said that many details need to be resolved to make Medicaid work.

Altman's initial goal is to raise the current \$7 office rate to \$13-\$15 while enrolling between 1,000 and 1,200 physicians to participate in the Plan.

Ultimately, said Altman, he would like to see Medicaid rates increased to Medicare levels.

PHYSICIAN ASSISTANTS LOSE GROUND

A bill which reaffirms a simple truth—that the Legislature alone has the authority to establish licensing for health care professions—is moving through the Assembly over the objections of a group of physician assistants (PA).

As released by the Health and Human Resources committee, the bill says that no category of health profession should practice, or be licensed to practice, by any state agency unless first authorized by the Legislature. MSNJ and the Nurses Association both testified in favor of the bill before the committee.

Now a "generic" bill addressing all unlicensed health care occupations, A-1591 originally dealt specifically with PAs. Sponsored by Assemblyman John Bennett (R, Freehold), the bill was a response to the Health Department's attempt to persuade the Board of Medical Examiners to license PAs by regulation.

An identical bill, S-1491, has been introduced by Senator Thomas S. Gagliano (R, West Long Branch).

MEDICARE ASSIGNMENT: IT'S BACK!

Two bills which would require physicians to accept Medicare assignment, or else lose their licenses, are among the more than 5,000 measures introduced in the first month of the 1988-89 Legislature.

Sponsors of the identical measures are Senator Carmen A. Orechio, Democrat of Nutley, and Assemblyman Alan J. Karcher, Democrat of Sayreville. The bills, S-1649 and A-2305, have been referred to the Health Committees in their respective houses.

Action on this issue more likely would occur this session in the Senate. As Society members so vividly recall, a Medicare assignment bill (A-2511) was voted down unanimously by the Assembly Health Committee less than a year ago. We're in a new legislative session, but the committee's membership is unchanged.

The Senate committee last year did not schedule a

hearing on the Medicare assignment bill. Senator Orechio discussed the issue thoroughly with the Essex County Medical Society and various senior citizens' groups, learned about the "courtesy" program in Essex and other counties, and was apprised of the Assembly committee's vote.

Whether the bill will be scheduled for committee consideration in the Senate is difficult to predict. Perhaps the most important factor is to what degree the "courtesy" programs are successful.

COMMITTEE ROSTERS ANNOUNCED

Senate President John F. Russo and Assembly Speaker Chuck Hardwick have named the following members to serve on the reference committees which will review bills affecting medicine in the 1988-89 Legislature:

Senate

Institutions, Health and Welfare

Richard J. Codey (D, West Orange), Chair

Francis J. McManimon (D, Trenton)

Gabriel M. Ambrosio (D, Lyndhurst)

C. Louis Bassano (R, Union)

John H. Dorsey (R, Mountain Lakes)

Labor, Industry and Professions

Raymond Lesniak (D, Elizabeth), Chair

Christopher J. Jackman, (D, North Bergen)

Edward T. O'Connor, Jr., (D, Jersey City)

Gerald Cardinale (R, Cresskill)

Donald T. DiFrancesco (R, Scotch Plains)

Judiciary

Edward T. O'Connor, Jr., (D, Jersey City), Chair

Raymond J. Zane (D, Woodbury)

Gabriel M. Ambrosio (D, Lyndhurst)

Richard J. Codey (D, West Orange)

John A. Lynch (D, New Brunswick)

Carmen A. Orechio (D, Nutley)

Richard Van Wagner (D, Red Bank)

Donald T. DiFrancesco (R, Scotch Plains)

John H. Dorsey (R, Mountain Lakes)

William L. Gormley (R, Atlantic City)

Lee B. Laskin (R, Cherry Hill)

Assembly

Health and Human Resources

Harold L. Colburn, M.D., (R, Mount Holly), Chair

Nicholas R. Felice (R, Fair Lawn)

Rodney P. Frelinghuysen (R, Morristown)

Thomas J. Deverin (D, Elizabeth)

George J. Otlowski (D, Perth Amboy)

Higher Education and Regulated Professions

Jeffrey Moran (R, Forked River), Chair

Dolores G. Cooper (R, Atlantic City)

Jack Collins (R, Woodstown)

Joseph V. Doria (D, Bayonne)

Anthony Imprevuto (D, Secaucus)

Insurance

Ralph A. Loveys (R, Parsippany), Chair

Clare M. Farragher (R, Freehold)

Richard Kamin (R, Succasunna)

Michael F. Adubato (D, Newark)

Joseph Charles, Jr. (D, Jersey City)

LEGISLATIVE UPDATE

Status of Legislation on Which MSNJ Has Taken an Active Position

Bill	Subject	MSNJ Position	Committee	Present Status
S-100 Bubba	Requires physicians to personally present and obtain surgical consent forms and signatures. The form shall state the name of any assisting physician that performs surgery under the supervision of the attending.	Active Opposition	Senate: LIP	In committee
S-124 Bubba	Requires express written consent to surgery except in cases of physical or mental incapacity or emergencies. The State Board, after consultation with the Health Department, MSNJ, and the Hospital Association shall prescribe the consent forms which shall be used by physicians.	Active Support	Senate: LIP	Passed in Senate; in Assembly committee (HHR)
S-179 Brown	Requires the Department of Health to prepare a booklet on breast cancer which must be given to breast cancer patients by their physicians.	Active Opposition	Senate: IHW	Out of committee; 2nd reading
S-281 Dumont	Provides for a three-year statute of limitations, except for fraud, intentional concealment, or nontherapeutic or diagnostic purpose. Minors have until age 11 on any injury prior to age 8.	Active Support	Senate: JUD	In committee
S-345 Ewing	Creates a commission to advise the governor and the legislature regarding any new proposals to regulate or license new professions.	Active Support	Senate: LIP	Out of committee; 2nd reading
S-403 Rand	Grants immunity to peer review organizations when the organization is recognized by the Dept. of Health. Also, provides for confidentiality of materials and records of the PRO.	Active Opposition	Senate: IHW	In committee
S-440 Garibaldi	Provides that cancers caused by exposure to heat, cold, radiation, or a known carcinogen which manifest themselves in active police or firemen are assumed to be accidental and work-related disabilities.	Active Opposition	Senate: SGF&IR&VA	In committee
S-492 Garibaldi	Requires a second physician to be present at any termination of pregnancy procedure if the attending has determined the unborn fetus is 24 weeks of age or older. The second physician is to provide immediate care to the child if it is born alive.	Active Opposition	Senate: IHW	In committee

Assembly Reference Committees

HHR: Health and Human Resources
 HERP: Higher Education and Regulated Professions
 JUD: Judiciary
 SG: State Government
 INS: Insurance
 SC: Senior Citizens
 EDA: Economic Development and Agriculture

Senate Reference Committees

LIP: Labor, Industry, and Professions
 SGF&IR&VA: State Government, Federal & Interstate Relations & Veterans Affairs
 IHW: Institutions, Health & Welfare
 JUD: Judiciary
 RFA: Revenue, Finance & Appropriations
 CH: Children Services

Bill	Subject	MSNJ Position	Committee	Present Status
S-493 Garibaldi	Requires the State Board of Medical Examiners to conduct a study as to when fetal viability occurs so that the conduct of physicians may be governed accordingly. Having conducted such a study, the Board is to promulgate guidelines regarding the termination of pregnancy.	Active Opposition	Senate: IHW	In committee
S-539 Cardinale	Exempts the private practice of medicine from the certificate of need law.	Active Support	Senate: IHW	In committee
S-600 Bassano	Requires every physician attending a woman at the time of delivery, miscarriage, abortion, or during the prenatal period to perform an Rh test. If the test is Rh negative the physician shall, within 24 hours of the receipt of result, advise patient of its significance and availability of preventive treatment.	Active Opposition		Signed into law as c. 166 P.L. 1987*
S-935 Feldman	Provides that within 60 days of filing an action against a physician the plaintiff must provide an affidavit from an expert that there has been negligent deviation from the accepted standards of practice.	Active Support	Senate: JUD	In committee
S-962 Feldman	Makes the decision of an Administrative Law Judge final in contested agency actions.	Active Support	Senate: JUD	In committee
S-1197 Jackman	Creates a separate licensing and regulatory board for chiropractic.	Active Opposition	Senate: LIP	In committee
S-1221 Codey	Removes the requirement that the State Commissioner of Health shall be a duly licensed physician.	Active Opposition	Senate: IHW	In committee
S-1241 Codey	Amends the certificate of need to include physicians whenever a health service has been regionalized by regulation of the Department of Health. Regulation would terminate within three years, at which time, the Commissioner could readopt the regulation.	Active Opposition	Senate: IHW	In committee
S-1283 Hirkala	Extends confidentiality to data in the possession of hospital peer review committee.	Active Support	Senate: IHW	In committee
S-1309 Contillo	Provides for a nonbinding referendum concerning the enactment of a national health plan.	Active Opposition		Passed in Senate; in Assembly HHR
S-1583 Lesniak	Provides that physicians shall not be exempted from malpractice claims by fellow employees.	Active Opposition	Senate: LIP	In committee
S-1801 Dorsey	Requires food processors and public eating places to provide written notice regarding irradiated foods.	Active Opposition	Senate: IHW	In committee
S-1841 Dalton	Provides that collateral sources of payment shall be used to offset damages. Further provides that periodic payments may be used at the request of either party if the future damages exceed \$100,000.	Active Support	Senate: JUD	In committee

Bill	Subject	MSNJ Position	Committee	Present Status
S-1878 Cardinale	Limits noneconomic damage awards to \$100,000.	Active Support	Senate: JUD	In committee
S-1979 McManimon	Eliminates the requirement that prescriber's address and registry number be included on the prescription label.	Active Support	Senate: IHW	Signed into law as c.75 P.L. 1986*
S-2041 McManimon	Establishes local area health planning agencies to continue the program being terminated by the federal government. Funds will be provided by the state with an offset for any federal money received.	Active Opposition	Senate: IHW	In committee
S-2102 McNamara	Establishes a demonstration project to allow hospitals to designate surplus acute beds as swing beds for skilled nursing care.	Active Support	Senate: IHW	In committee
S-2129 Russo	Prohibits physicians from employing physical therapists, owning a physical therapy practice, or any interest in a physical therapy practice.	Active Opposition	Senate: IHW	In committee
S-2137 McManimon	Creates a "local health planning" system to operate the certificate of need apparatus. The agencies would be funded by a special tax on hospitals.	Active Opposition	IHW	In committee
S-2187 Brown	Allows a licensed professional registered nurse to serve as the Commissioner of Health.	Active Opposition	Senate: IHW	In committee
S-2261 Lynch	Permits optometrists to use drugs for treatment and diagnostic purposes.	Active Opposition	Senate: IHW	Laid over
S-2290 Bassano	Makes AIDS reportable. Grants immunity to physicians who deem it advisable to inform patient's sexual partners.	Active Support	Senate: JUD	In committee
S-2385 Cardinale	Places a \$350,000 cap on awards for pain and suffering. The limit shall be revised annually by the Consumer Price Index—U.S.—City Average.	Active Support	Senate: JUD	In committee
S-2398 Bassano	Eliminates joint and several liability.	Active Support	Senate: JUD	In committee
S-2403 Bassano	Provides that benefits from collateral sources shall be deducted from awards in personal injury actions.	Active Support	Senate: JUD	In committee
S-2473 Orechio	Requires health care licensees to accept Medicare determination of their fees.	Active Opposition	Senate: IHW	In committee
S-2585 Garibaldi	Requires health care licensees to accept Medicare determinations of their fees.	Active Opposition	Senate: IHW	In committee
S-2644 Lesniak	Limits noneconomic loss in tort cases to \$500,000 unless the injury includes significant and severe permanent disability including permanent disfigurement.	Active Opposition	Senate: JUD	In committee
S-2703 Lesniak	Modifies the application of joint and several liability in tort actions.	Active Opposition	Senate: JUD	Signed into law as c.325 P.L. 1987*
S-2706 Lesniak	Provides for structured payments exceeding \$200,000.	Active Support	Senate: JUD	In committee

Bill	Subject	MSNJ Position	Committee	Present Status
S-2707 Russo	Limits noneconomic loss in tort cases to \$500,000 unless the injury includes significant and severe permanent disability including permanent disfigurement.	Active Opposition	Senate: JUD	In committee
S-2721 Lipman	Authorizes nurses to practice medicine and to prescribe drugs and devices.	Active Opposition	Senate: LIP	In committee
S-3284 Zimmer	Permits emergency medical technicians certified by the Commissioner of Health as an EMT-D to perform cardiac defibrillation.	Active Support	Senate: IHW	In committee
S-3500 McManimon	Allows psychologists to certify disability.	Active Opposition	Senate: LIP	In committee
S-3696 McManimon	Appropriates \$650,000 to fund local health planning.	Active Opposition	Senate: RFA	In committee
SR-5 Bubba	Requests Congress to reject taxing health benefit packages.	Active Support	Senate: SGF&IR&VA	In committee
SR-59 Pallone	Condemns HCFA for deliberate delays in processing Medicare claims.	Active Support	Senate: IHW	In committee
SJR-42 McManimon	Establishes a commission to study the possibility of using health enterprise zones in New Jersey to counteract adverse market conditions.	Active Support	Senate: IHW	Out of committee; 2nd reading
A-137 Muhler	Creates a 27-person Board within the Department of Human Services vested with the authority to release or continue the commitment of persons who were found incapable of standing trial or not guilty by reasons of insanity. A Superior Court judge currently makes these decisions.	Active Opposition	Assembly: HHR	In committee
A-181 Villanc	This bill would establish and license two categories of social workers and would create a Board of Social Work Examiners in the Department of Law and Public Safety whose powers and duties, among others, would be to administer the act, examine and license candidates for the various categories of social work, and promulgate rules and regulations necessary for the effective enforcement of the act. The two categories of licensed social work would be 1) social work specialists, who would be required to have a doctorate in social work or a master's degree from an accredited school of social work and 2) social workers who would need a baccalaureate degree from an accredited college or university social work or social welfare program. The bill would "grandfather" in all persons in practice in one of the two licensed categories for two of the last five years who apply to be licensed within 180 days from act date.	Active Opposition	Assembly: HERP	In committee

Bill	Subject	MSNJ Position	Committee	Present Status
A-200 Kosco	Creates a Commission to study the certificate of need process. The Commission would consist of 15 members. Two of the 15 would be physicians. Their report is to be submitted to the legislature and the governor.	Active Support	Assembly: HHR	Passed in Assembly; In Senate committee JUD; 2nd reading
A-360 Garvin	Requires the Department of Health and the State Board of Medical Examiners to prepare a booklet on all aspects of the treatment of breast cancer. Attending physicians are required to distribute the book to appropriate patients and to discuss it with them.	Active Opposition	Assembly: HHR	In committee
A-478 Muziani	Directs the State Board of Medical Examiners to review the issue of when fetal viability occurs and to provide guidelines to physicians regarding procedures to terminate pregnancy.	Active Opposition	Assembly: HHR	In committee
A-479 Muziani	Requires a second physician to be present whenever a physician terminates a pregnancy involving a live fetus of 24 weeks of age or older.	Active Opposition	Assembly: HHR	In committee
A-482 Muziani	Requires a physician to advise pregnant patients of the effects of alcohol and certain drugs on a fetus. The woman shall sign a form confirming the advice was given. The physician is to retain the original and provide the patient with a copy.	Active Opposition	Assembly: HHR	In committee
A-716 Miller	Allows patients or insurers to appeal excessive charges under the DRG program.	Active Support	Assembly: HHR	In committee
A-718 Miller	Terminates the DRG program and requires the Department of Health to develop an alternate system within one year.	Active Support	Assembly: HHR	In committee
A-737 Miller	Provides that collateral sources of payment shall be used to offset damages. Further provides structured payments may be used at the request of either party if the future damages exceed \$100,000.	Active Support	Assembly: JUD	In committee
A-738 Miller	Provides a \$100,000 cap on damages for pain and suffering to personal injury actions.	Active Support	Assembly: JUD	In committee
A-739 Miller	Establishes a 3-year statute of limitations in tort actions against health care providers. Children would have until 11 to bring an action for injuries prior to age 8. After age 8, they come under the 3-year standard. Fraud, concealment, and unintentional foreign bodies "toll" the statute.	Active Support	Assembly: INS	Out of committee; amended; 2nd reading
A-740 Miller	Provides that within 60 days of filing a medical malpractice complaint, the plaintiff must supply an affidavit, by a qualified expert, that reasonable cause exists to believe malpractice occurred.	Active Support	Assembly: INS	In committee

Bill	Subject	MSNJ Position	Committee	Present Status
A-776 Weidel	Provides that terminally ill patients may direct their physicians, through a written document to withhold or withdraw mechanical or artificial means to sustain or supplant vital function when those acts will only artificially prolong death. The directive shall comply with statutory form. The physician relying upon it shall determine it complies with the statute.	Active Opposition	Assembly: JUD	Out of committee; amended; 2nd reading
A-947 Schuber	Transfers the Office of Administrative Law from the Executive Branch to the Judicial Branch. The initial decision made by the agency directly or by report from an administrative law judge. All appeals would then be heard by another administrative law judge. The next appeal would be to the Appellate Division.	Active Support	Assembly: JUD	In committee
A-998 Doria	Creates a commission to review licensing legislation being proposed by any legislator. The commission is to file a report with the governor and the legislature on the necessity of establishing the licensing mechanism being reviewed.	Active Support	Assembly: HERP	Passed in Assembly; in Senate RFA Committee
A-1008 Doria	Creates a licensing board for chiropractic. Transfers all functions and responsibilities of the SBME regarding chiropractic to the new board. Removes the place for a chiropractor from the medical board.	Active Opposition	Assembly: HERP	In committee
A-1422 Mazur	Proposes a nonbinding referendum on whether national health insurance is desirable.	Active Opposition	Assembly: HHR	In committee
A-2283 Kelly	Limits damages for noneconomic loss to \$250,000 in civil suits.	Active Support	Assembly: INS	In committee
A-2373 Kavanaugh	Requires professional liability carriers to report all claims and awards to the Insurance Department. The Department shall report to the licensing boards and they will make the information public.	Active Opposition	Assembly: INS	In committee
A-2379	Establishes local area health planning agencies to continue the program being terminated by the federal government. Funds will be provided by the state with an offset for any federal money received.	Active Opposition	Assembly: HHR	In committee
A-2380 Kern	Same as A-2379 except that this bill also appropriates \$1.8 million to fund the system.	Active Opposition	Assembly: HHR	In committee
A-2400 Loveys	Establishes a three-tier monetary cap on award for pain and suffering. The caps are \$5,000 for minor injury, \$300,000 for major injuries, and \$100,000 for all others. The bill also places limits on overall liability of public entities.	Active Support	Assembly: INS	Passed in Assembly; in Senate JUD committee

Bill	Subject	MSNJ Position	Committee	Present Status
A-2401 Weidel	Eliminates joint and several liability and establishes the collateral source rule so that plaintiffs cannot collect more than once for the same loss. Establishes that state-of-the-art, adequate warning and open and obvious defenses for product liability. Also, provides that 95 percent of punitive damages will be paid to the state, rather than the plaintiff. Establishes a fund to pay excess awards levied against public entities.	Active Support	Assembly: INS	Passed in Assembly; in Senate JUD committee
A-2402 Zecker	Requires structured settlements for awards in excess of \$300,000.	Active Support	Assembly: INS	Passed in Assembly; in Senate JUD committee
A-2403 Kelly	Requires arbitration of all claims below \$20,000.	Active Support	Assembly: INS	Passed in Assembly; in Senate JUD committee
A-2404 Rafferty	Requires insurance companies to provide the New Jersey Insurance Department with specific data to support its rate request.	Active Support	Assembly: INS	Out of committee; 2nd reading
A-2428 Deverin	Provides for arbitration of claims when the noneconomic loss asserted is less than \$20,000.	Active Support	Assembly: INS	In committee
A-2495 Moran	Requires the New Jersey Division on Aging and the New Jersey Department of Health to publish a list of doctors who charge more than Medicare allowances. Senior citizens who are charged more than Medicare allowances are encouraged to file complaints with the county office on aging.	Active Opposition	Assembly: SC	Out of committee; 2nd reading
A-2511 Doyle and Karcher	Requires health care providers to accept Medicare assignment.	Active Opposition	Assembly: HHR	In committee
A-2519 Doria	Professional liability bill.	Active Opposition	Assembly: INS	In committee
A-2535 Kelly	Authorizes nurses to prescribe medications.	Active Opposition	Assembly: HERP	In committee
A-2559 Felice	Prohibits institutions from operating retail pharmacies within 1,500 feet of their facility.	Active Opposition		Passed in Senate and Assembly
A-2603 Kelly	Requires food processors and retailers to provide written notice if food has been preserved by radiation.	Active Opposition	Assembly: EDA	Out of committee; 2nd reading
A-2647 Haytaian	Prohibits physicians from employing physical therapists, owning a physical therapy practice, or any interest in a physical therapy practice.	Active Opposition	Assembly: HERP	Out of committee; amended; 2nd reading
A-2651 Villane	Provides for the licensing of social workers and would allow them to engage in psychotherapy.	Active Opposition	Assembly: HHR	In committee
A-2878 Doria	Permits dentists who have had their credentials approved to practice in hospitals.	Active Opposition	Assembly: HERP	In committee

Bill	Subject	MSNJ Position	Committee	Present Status
A-3305 Singer	Requires licensed health care providers who treat Medicare enrollees to accept the Medicare fee determination if the beneficiary presents to the provider a valid PAAD card.	Active Opposition	Assembly: HHR	In committee
A-3434 Loveys	Amends the Insurance Fraud and Prevention Act to eliminate the verification of medical bills submitted with insurance claims.	Active Support	Assembly: INS	Signed into law as c. 342 P.L. 1987*
A-3438 Colburn	Creates a study commission to review the DRG program for its impact on the quality of care and to determine whether it should be continued.	Active Support	Assembly: HHR	Passed in Assembly; in Senate committee (IHW)
A-3751 Loveys	Requires structured payments when future damages exceed \$200,000 by means of an annuity contract.	Active Support	INS	In committee
A-3777 Colburn	Allows hospitals to undertake outpatient projects costing no more than \$2,000,000 without obtaining a certificate of need.	Active Support	INS	In committee
A-4465 Penn	Permits psychologists to certify disability under the temporary disability benefits law.	Active Opposition	LIP	In committee
A-4466 Loveys	Eliminates joint and several liability except for environmental torts.	Active Support	INS	Out of committee; 2nd reading
A-4515 Kern	Appropriates \$650,000 to fund local health planning.	Active Opposition	HHR	In committee
A-4615 Loveys	Provides for structured payments of future damages exceeding \$200,000.	Active Support	INS	Out of committee; 2nd reading
AJR-49 Felice	Directs the Commissioner of Health to study and report on the feasibility of health enterprise zones.	Active Support		Signed into law as c. JR6 P.L. 1987*
AR-141 Singer	Commends the Union and Ocean County Medical Societies for their senior citizen medical courtesy programs.	Active Support	HHR	In committee
AR-143 Farragher	Requests Congress to raise fees to doctors participating in Medicare.	Active Support	HHR	In committee
AR-156 Kalik	Requests Congress to provide Medicare recipients with catastrophic illness coverage.	Active Support	HHR	In committee

N.B. All of the foregoing bills expired at the end of the 1986-1987 Legislative Year or were filed or conditionally vetoed by the Governor. The asterisk (*) denotes bills that were signed into law during this time.

WHOM TO CALL AT MSNJ HEADQUARTERS

Executive Director: Vincent A. Maressa

Address changes	Peggy Smith	Long-Range Planning	
Advertising (in NEW JERSEY		Committee	Vincent A. Maressa
MEDICINE)	Joseph Cookson	Loss Prevention, Risk	
AMA Delegation	Diana C. Gore	Management	A. Ronald Rouse
Annual Meeting	Eileen Pfeiffer	Maternal and Newborn Record	
Auxiliary, MSNJ	Margaret Franskiewich	Books	Joyce Guest
Biomedical Ethics	June O'Hare	Medical Assistants	Joseph C. Lucci
Blue Cross/Blue Shield	Joseph C. Lucci	Medical Education	Martin E. Johnson
Board of Trustees	Diana C. Gore	Medical Services	Joseph C. Lucci
Continuing Medical		Medical Student Loan	
Education	Martin E. Johnson	Fund	Patricia Drakeford
Council and Committee		Medicare/Medicaid	Joseph C. Lucci
Appointments	Diana C. Gore	Membership Benefits	Joseph C. Lucci
Credentials	Mary Hamer	Membership Directory	Joyce Guest
Delegates, MSNJ	Eileen M. Pfeiffer		Arthur White
DRG	Vincent A. Maressa	Membership Records	Mary Hamer
Dues Payments: MSNJ and		Mental Health	Joseph C. Lucci
AMA	Mary Hamer	NEW JERSEY MEDICINE .	Geraldine Hutner
Eye Health Screening		Nominating Committee	Diana C. Gore
Program	Patricia Hackett	Officers of MSNJ	Diana C. Gore
Executive Committee	Diana C. Gore	PRO	Vincent A. Maressa
Financial Operations	Arthur White	Professional Liability	
HMOs/IPAs/PPOs	Joseph C. Lucci	Insurance	A. Ronald Rouse
Hospital Medical Staff		Public Health	Joseph C. Lucci
Relations	Diana C. Gore	Public Relations	Martin E. Johnson
House of Delegates	Diana C. Gore	Resident Association	A. Ronald Rouse
Impaired Physicians		Resolutions for Annual	
Program	David I. Canavan, M.D.	Meeting	Diana C. Gore
	Linda A. Pleva	Senior Citizen Projects	A. Ronald Rouse
	Edward G. Reading	Special Projects	A. Ronald Rouse
JEMPAC	June O'Hare	Specialty Societies	Patricia Hackett
Judicial Council	June O'Hare	Student Association	A. Ronald Rouse
Legal Services Plan	Joseph C. Lucci	Subscriptions	Robin L. Kennett
Legal Questions	Vincent A. Maressa	Third-Party Payor	
Legislation	June O'Hare	Complaints	Joseph C. Lucci
Liaison Representatives to Other		Widows and Orphans Program .	Joyce Guest
Organizations	Diana C. Gore	Women Membership	Martin E. Johnson

MSNJ-609-896-1766



The World's Most Popular K^{*}

Slow-K[®]
potassium chloride
slow-release tablets
8 mEq (600 mg)

It means "dependability" in almost any language

*Based on worldwide sales data on file, CIBA Pharmaceutical Company.
Capsule or tablet slow-release potassium chloride preparations should be reserved for patients who cannot tolerate, refuse to take, or have compliance problems with liquid or effervescent potassium preparations because of reports of intestinal and gastric ulceration and bleeding with slow-release KCl preparations.

Before prescribing, please consult Brief Prescribing Information on next page.

C I B A

The World's Most Popular K

For good reasons

- ❑ **It works**—a 12-year record of efficacy¹
- ❑ **It's safe**—unsurpassed by any other KCl tablet or capsule^{2*}
- ❑ **It's acceptable vs liquids**—greater palatability, fewer GI complaints, lower incidence of nausea²
- ❑ **It's comparable to 10 mEq**—in low-dosage supplementation^{3†}
- ❑ **It's economical**—less expensive than all other leading KCl slow-release supplements on a per tablet cost to the patient¹



Slow-K®
potassium chloride
slow-release tablets 8 mEq (600 mg)

For patients who can't or won't tolerate liquid KCl.

*The most common adverse reactions to potassium salts are gastrointestinal side effects.

†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

C I B A

References: 1. Data on file, CIBA Pharmaceutical Company. 2. Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. 3. Skoutakis VA, Carter CA, Acchiardo SR: Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

Slow-K®
potassium chloride USP
Slow-Release Tablets
8 mEq (600 mg)

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)

INDICATIONS AND USAGE

BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.
2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure; hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS

Hyperkalemia (See OVERDOSAGE).

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis

Hyperkalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS

General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients

Physicians should consider reminding the patient of the following:

To take each dose without crushing, chewing, or sucking the tablets.
To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.

To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions

Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproductive capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 mEq of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSEAGE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

HOW SUPPLIED

Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K).

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Consumer Pack—One Unit
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C87-31 (Rev. 8/87)

C I B A

128-3568-A

A National Disgrace

A Health Service Grant awarded to the Academy of Medicine of New Jersey focuses on physician education in the prevention of diabetes-related lower extremity amputations.

The word association with diabetes in the minds of many people is gangrene or leg amputation. Unfortunately, that is more true in 1988 than we would like to believe and that is a national disgrace.

Several years ago, the National Institutes of Health, Centers for Disease Control, through the New Jersey State Department of Health Diabetes Control Program, designated New Jersey as a Diabetes Control Demonstration State. One of our initial and major interests has been lower extremity amputations (LEAs). A study of the subject in New Jersey was reported in this journal in 1985 by Miller et al.¹ The data showed that 1,448 LEAs were performed each year between 1979 and 1981 and further tracking has shown an increase to 1,800 in 1986.

That shocking statistic must be coupled with cost: \$20 million per year for hospital costs alone, with an extrapolated total annual cost of \$100 million to our

state when one considers direct and indirect costs—lost wages, lost taxes, and premature death.² Furthermore, it points up that the national figures are understated and that there probably are 100,000 LEAs each year in the United States with an extrapolated health care cost of \$6 to \$7 billion. The disgrace is that half of those LEAs can be prevented.

The Academy of Medicine of New Jersey was awarded a Health Service Grant, through the Centers for Disease Control-New Jersey State Department of Health entitled "Physician Education—Prevention of Diabetes-related Lower Extremity Amputations (LEAs)." We now are hard at work implementing the program. The premise of our approach is that the key figures in this drama are the patient and the family physician. Thus, the program will work in conjunction with the New Jersey Academy of Family Physicians with the cooperation of the New Jersey Pharmaceutical Association.

The key elements of this three-year educational and research program, which initially will be aimed at the two counties with the highest amputation rates and two control counties, will include the following:

- A two-hour video program on primary, secondary, and tertiary prevention of LEAs.
- A two-hour workshop, "Prevention of Lower Extremity Amputations in Diabetics," at the New Jersey Academy of Family Practice Annual Meeting in 1988, 1989, and 1990.
- Roving Symposia arranged by the Academy of Medicine of New Jersey in the two research counties.
- Statewide Roving Symposia.
- A monograph on prevention of LEAs in diabetes will be distributed.
- A newsletter and additional materials on the subject will be distributed during the project.
- Selected family physicians will be offered an opportunity to participate in the research component of the project.

We hope to demonstrate that education, enhanced skills and knowledge, and change in behavior by both patients and physicians can reduce the loss of legs and money by persons with diabetes in our state. We will need your participation.

A.K.

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1. Miller AD, Van Buskirk A, Verhoek-Oftedahl W, Miller ER: Diabetes-related lower extremity amputations in New Jersey, 1979 to 1981. *J Med Soc NJ* 82:723-726, 1985.
2. Krosnick A: Economic impact of type II diabetes mellitus. *Primary Care Clinics*, 1988 (in press).

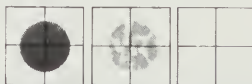


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Preventing Tobacco Dependence

JOHN D. SLADE, M.D.*

The New Jersey Commission on Smoking or Health is ready to help us focus on the problems caused by tobacco.

The report by the Commission on Smoking or Health on children and tobacco which appeared in last month's special issue of *NEW JERSEY MEDICINE* summarized a variety of approaches for controlling the tobacco epidemic by focusing prevention efforts on the initial stages of nicotine dependence.¹ Since the original report was issued, the Commission added two recommendations.

The first item concerned the Commission's recommendation for smoke-free environments for children. The original report contains a recommendation that all primary and secondary schools be completely tobacco-free. Because of the risk of involuntary smoking to children² and because of the way children model adult behavior, the Commission has extended this recommendation to apply to any place where children usually are present. This includes not only schools, but day care facilities, latch-key programs, and recreational and entertainment facilities for the young. It also includes homes in which there are children.

The second item is a new recommendation, concerning the substantial proportion of teenagers in New Jersey that already have nicotine dependence. A survey conducted by the State Department of Law and Public Safety among 10th, 11th, and 12th graders indicates

that 40 percent of those surveyed use tobacco regularly, and half use it daily.³ In addition to preventing the onset of tobacco use, treating nicotine dependence in this age group should be a priority for public health and education officials. Treatment in this population has not been well studied up to now, but this situation may be improving.⁴

The Commission on Smoking or Health has a diverse membership, and each individual has made substantial contributions. Those who compiled the report on children are: Mrs. Thomas Kean, Honorary Chairperson; Dr. Lee Reichman, Chairperson, Department of Medicine, UMDNJ-New Jersey Medical School; Mrs. Laura Bauvais-Godwin, New Jersey Chapter, Society for Public Health Education; Mrs. Regina Carlson, New Jersey Group Against Smoking Pollution; Mrs. Jane DeMaio, New Jersey State Department of Education; Mrs. Iolanda Gaglioti, New Jersey Congress of Parents and Teachers; Mr. Richard Gardiner, New Jersey State Department of Treasury; Mrs. Shirley Greene, New Jersey Interagency Council on Smoking or Health; Dr. Norman Hymowitz, Department of Psychiatry, UMDNJ-New Jersey Medical School; Mr. Daniel Jordan, New Jersey Health Officers Association; Mr. Lester Kurtz, New Jersey Business and Industry Association; Mr. Edward Lawson, Prudential Insurance Company; Mr. Richard Lloyd, Blue Cross and Blue Shield of New Jersey; Mr. Octavius Reid, New Jersey School Boards Association; Dr. John Slade, Department of Medicine, UMDNJ-Robert Wood Johnson Medical School; Mrs. Beulah Walter, American Association of Retired Persons, New Jersey Chapter; Dr. Richard Watson, Johnson and Johnson; and Dr. Elizabeth Wilson, New Jersey State Nurses Association. Staff support in the Department of Health was provided by Dr. Lawrence Meinert, Mrs. Janice Marshall, and Mr. George Wasser.

The Commission now is seeking ways to implement the recommendations it has developed. The Board of Trustees of the Medical Society of New Jersey have endorsed the report. We ask that each of you also join in this effort.

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1. The New Jersey Commission on Smoking or Health: Preventing tobacco dependence. *NEW JERSEY MEDICINE* 85:151-155, 1988.
2. Office on Smoking and Health: *The Health Consequences of Involuntary Smoking*. Rockville, MD, Centers for Disease Control, U.S. Government Publication No. DHHS (CDC) 87-8398, 1986.
3. Fisher, WS: *Drug and Alcohol Use Among New Jersey High School Students 1987*. Trenton, New Jersey Department of Law and Public Safety, 1987.
4. Weissman W, Glasgow R, Biglan A, Lichtenstein E: Development and preliminary evaluation of a cessation program for adolescent smokers. *Psychol Addictive Behav* 1:84-91, 1987.

*Dr. Slade was the Guest Editor for our special issue on Tobacco Dependence (February 1988). Correspondence may be addressed to Dr. Slade, St. Peter's Medical Center, 254 Easton Avenue, New Brunswick, NJ 08903.

Before prescribing, see complete prescribing information in SK&F LAB CO. literature or PDR. The following is a brief summary.

Contraindications: There are no known contraindications to the use of 'Tagamet'.

Precautions: While a weak antiandrogenic effect has been demonstrated in animals, 'Tagamet' has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl (brand of cimetidine hydrochloride) injection by intravenous bolus.

Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlordiazepoxide, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.),

demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly un-

likely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only), and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).

Liquid: 300 mg./5 ml., in 8 fl. oz. (237 ml.) amber glass bottles and in single-dose units (300 mg./5 ml.), in packages of 10 (intended for institutional use only).

Injection:

Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose prefilled disposable syringes.

Plastic Containers: 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

ADD-Vantage® Vials: 300 mg./2 ml. in single-dose, ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl (brand of cimetidine hydrochloride) Injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

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BRS-TG:173B

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RESULTS

How To Avoid Legal Problems

Medical Office Claims Prevention Study; Referral Follow-Through

MEDICAL OFFICE CLAIMS PREVENTION SURVEY

A most productive approach to avoiding problems.

In an effort to reduce their liability exposure, physicians often ask insurance carriers for a profile of the litigious patient. Physicians and other caregivers believe that, armed with this information, they can eliminate such individuals from their practices.

Unfortunately, although some demographic data exists about litigants, there is no meaningful way to predict who will sue. The fact is that every malpractice insurer has had claims filed by individuals from every socioeconomic, ethnic, racial, and financial group, including physicians and other health professionals. No credible studies have been reported which support the allegation that "welfare patients" are more litigious than other more affluent patients. When you consider that plaintiffs' lawyers' fees are a percentage of awards, the patient who cannot claim a wage loss, out-of-pocket expenses, or promising future wages is less likely to attract an attorney's interest in his case.

In search of the so-called litigious patient, physicians in several states have tried to screen potential litigants by computerized tracking of plaintiffs in malpractice suits. For a fee, physicians could call a hotline to check on prospective "bad patients." The plaintiffs' bar countered with a computerized list of physicians named in lawsuits; patients could call the attorneys' hotline for the names of these "bad physicians." The physicians protested, arguing that being sued for malpractice does not necessarily mean that a physician is a bad physician. Using the same logic, the plaintiffs' bar countered that the fact that an individual sues for malpractice does not mean that he or she is a litigious individual who should be blacklisted by the medical community.

In actuality, very few malpractice plaintiffs are pro-

fessional litigants. These hotline wars emphasize the futility of attempting to predict lawsuits by fingering past defendants or plaintiffs. It is more productive to identify the causes of litigation and to develop ways to avoid the problems which prompt suits.

It was on this premise that California's first physician-owned malpractice carrier, Medical Insurance Exchange of California (MIEC), developed its Claims Prevention Survey program for physicians' offices. These office practice surveys draw upon closed malpractice claims data, deposition and courtroom testimony of plaintiffs and medical experts, and the expertise of claims prevention specialists to educate physicians and their staff about the leading iatrogenic causes of claims. The surveys also address nonmedical practice-related issues, including inadequate or inappropriate policies and procedures which trigger litigation.

The surveys do not attempt to evaluate the physicians' medical abilities. MIEC's Liability and Risk Assessment Program in which peer consultants assess a physician's adherence to standards of practice is used for this purpose. The office practice surveys do recognize, however, that not every bad outcome or patient injury results in a lawsuit, and that many litigants who may not have a meritorious claim nevertheless are sufficiently angered by a nonmedical issue to peruse a claim. The surveys focus on identifying and eliminating these problems in individual and group practices.

Methodology. The MIEC Claim Prevention Survey begins with a review by a claims prevention specialist of a random selection of medical charts to analyze the physician's recordkeeping practices. More than 50 documentation factors are considered. Medical judgments are not addressed in this review. Because many malpractice claims are lost or settled because of the poor quality of medical records, in some ways, this is the most important part of the survey process.

Next, the claims prevention specialist meets with the physician for 90 minutes or more to discuss the leading causes of malpractice claims in the doctor's specialty. Pertinent medical-legal issues, such as informed consent, are reviewed, as are the relationship between patient education and medications in litigation. Because the surveyor has reviewed actual medical records and is knowledgeable about malpractice liabilities in the physician's specialty, the office practice survey discussion and the recommendations are quite personalized.

After the conference with the physician, the surveyors meet with the office staff to discuss the many ways they can identify and prevent malpractice liabilities. This is an important step in the survey because it often is the only opportunity that office personnel have to discuss medical-legal topics and to ask questions about their own roles in the office that could have a bearing on possible litigation. Subjects discussed range from patient relations to documentation of what transpired in the patient's visit or call to the office as well as an analysis of medical-legal issues.

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are Director of the Department and Director of Special Projects, respectively.

doctrines, and forms with which allied health professionals must be familiar. Staff documentation, for example, is a process that often is not considered until a lawsuit arises.

The final step in the survey process is an inspection of the office premises to look for obvious and not-so-obvious liability problems. The availability and proximity of emergency equipment, for example, must be considered in some offices as well as the adequacy and safety of laboratory, x-ray facilities, and patient treatment areas.

What physicians learn. MIEC has conducted hundreds of these office practice surveys since 1979. Although most physicians agree to the free voluntary survey, some are initially skeptical about the merits of this approach in reducing malpractice claims. A common reservation is the anticipation that recommendations for change arising out of the survey will be unreasonable, costly, or time-consuming.

Instead, physicians surveyed invariably find that:

1. Better documentation does not mean more documentation.

2. Many office policies and practices that were acceptable in the past are inadequate today and in fact may promote patient injury.

3. The physician most vulnerable to a lawsuit is one who possesses inadequate communications skills and who fails to pass responsibility to patients to follow instructions, seek timely medical attention, and take medications as directed.

4. True "defensive medicine" does not mean ordering unwarranted tests or treatment.

5. The attitude of a physician's office staff may be the catalyst which sends some patients to an attorney in anger when a treatment problem occurs that would not lead other patients to sue.

Mr. David Karp, who regularly writes the material for *Loss Minimizer*, developed and administers MIEC's Claims Prevention Survey Program. (*Medical Liability Monitor*, October 23, 1987, Vol. 12, No. 10)

REFERRAL FOLLOW-THROUGH: IT'S UP TO YOU!

Gaps in the referral process can result in patient injury and litigation against the physicians involved. "I would like you to see a surgeon about your present problem. Why don't you call Dr. Smith for an appointment? Of course, it's your choice; you may already have another surgeon in mind. Just let me know how you make out."

Is this the end of the patient referral process? It should not be! However, in its routine review of cases, the Pennsylvania Medical Society Liability Insurance Company Claims Committee repeatedly has seen the above scenario result in subsequent litigation against the referring physician. The majority of these cases involve allegations of "failure to diagnose or delayed diagnosis/treatment of a patient's condition." Often involving malignancies or cardiac conditions, many of these cases have very high morbidity and mortality outcomes.

Problems arise when a physician recommends referral or consultation in the above manner, leaving the total responsibility for making the referral appointment with the patient. The patient may decide, for whatever reason, simply not to make the appointment. Thus, the physician's good intentions and diagnosis/

treatment plans are foiled and later, a malpractice suit is brought against him/her because the diagnosis or treatment was delayed. While a patient may be found to be contributorily negligent if a delayed diagnosis or treatment can be at least partially attributed to the patient's own delay or failure to see the recommended specialist, juries readily accept the argument that the physician better understands the consequences of a patient's noncompliance.

It is extremely important that the referring physician has some mechanism in place to see that his/her recommendations to the patient are carried out and that the patient indeed was seen by the recommended specialist. The best method for the physician to insure that the recommendation for referral/consultation is carried out is to immediately make the appointment for the patient, in the patient's presence. This way, you will know the appointment has been made and that it will take place in a timely fashion. Additionally, if necessary, the patient can be given any pertinent records information which should be conveyed to the subsequent treating physician. Of course, if time allows, these records can be mailed to the consultant accompanied by a letter describing the patient's condition and the reasons for the referral. If the referral appointment is not made before the patient leaves the referring physician's office, routine office procedure should include some type of followup mechanism to confirm that the recommended appointment was made by the patient.

A physician must convey the appropriate importance, necessity, and urgency behind his/her decision to refer. The patient should be told and understand why the physician is recommending referral to another physician, what you hope to accomplish by the referral, and, to the extent possible, what may happen as a result of the referral—diagnostic testing, hospitalization, or surgery. If the referral means that you no longer will be involved in any aspect of the patient's care, fully explain that to the patient as well. Patient anxiety can be reduced and patient delay or noncompliance usually can be effectively avoided when the patient understands why such a referral is indicated and what to expect. If, in spite of receiving this information, the patient refuses your referral recommendation, be sure to document that the patient was told and understood your referral recommendation as well as the consequences of noncompliance, and still elected not to follow your advice.

Additionally, once the referral is made—whether you are only seeking consultation or are actually turning treatment of the patient over to another physician—it is good practice to followup with the consultant or subsequent treating physician to insure that the patient was seen and to obtain the results of the referral for your records on that patient.

Conversely, if you are acting in the capacity of consultant or a subsequent treating physician, it is your responsibility to communicate the results of your consultation to the referring physician.

Too often, communication gaps in the referral process—be it physician-to-patient or physician-to-physician—can result in patient injury and, ultimately, litigation against the physicians involved in the patient's care. (*Patient Rx Newsletter*, November 1987, Vol. 9, No. 6)



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CONTRAINDICATIONS: Hypersensitivity to trimethoprim or sulfonamides; documented megaloblastic anemia due to folate deficiency; pregnancy at term and during the nursing period; infants less than two months of age.

WARNINGS: FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS.

BACTRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. Clinical signs, such as rash, sore throat, fever, pallor, purpura or jaundice, may be early indications of serious reactions. In rare instances a skin rash may be followed by more severe reactions, such as Stevens-Johnson syndrome, toxic epidermal necrolysis, hepatic necrosis or serious blood disorder. Perform complete blood counts frequently. **BACTRIM SHOULD NOT BE USED IN THE TREATMENT OF STREPTOCOCCAL PHARYNGITIS.** Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have a greater incidence of bacteriologic failure when treated with Bactrim than with penicillin.

PRECAUTIONS: General: Give with caution to patients with impaired renal or hepatic function, possible folate deficiency (e.g., elderly, chronic alcoholics, patients on anticonvulsants, with malabsorption syndrome, or in malnutrition states) and severe allergies or bronchial asthma. In glucose-6-phosphate dehydrogenase deficient individuals, hemolysis may occur, frequently dose-related.

Use in the Elderly: May be increased risk of severe adverse reactions in elderly, particularly with complicating conditions, e.g., impaired kidney and/or liver function, concomitant use of other drugs. Severe skin reactions, generalized bone marrow suppression (see WARNINGS and ADVERSE REACTIONS) or a specific decrease in platelets (with or without purpura) are most frequently reported severe adverse reactions in elderly. In those concurrently receiving certain diuretics, primarily thiazides, increased incidence of thrombocytopenia with purpura reported. Make appropriate dosage adjustments for patients with impaired kidney function (see DOSAGE AND ADMINISTRATION).

Use in the Treatment of Pneumocystis Carinii Pneumonitis in Patients with Acquired Immunodeficiency Syndrome (AIDS): Because of unique immune dysfunction, AIDS patients may not tolerate or respond to Bactrim in same manner as non-AIDS patients. Incidence of side effects, particularly rash, fever, leukopenia, with Bactrim in AIDS patients treated for *Pneumocystis carinii* pneumonitis reported to be greatly increased compared with incidence normally associated with Bactrim in non-AIDS patients.

Information for Patients: Instruct patients to maintain adequate fluid intake to prevent crystalluria and stone formation.

Laboratory Tests: Perform complete blood counts frequently; if a significant reduction in the count of any formed blood element is noted, discontinue Bactrim. Perform urinalyses with careful microscopic examination and renal function tests during therapy, particularly for patients with impaired renal function.

Drug Interactions: In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombocytopenia with purpura has been reported. Bactrim may prolong the prothrombin time in patients who are receiving the anticoagulant warfarin. Keep this in mind when Bactrim is given to patients already on anticoagulant therapy and reassess coagulation time. Bactrim may inhibit the hepatic metabolism of phenytoin. Given at a common clinical dosage, it increased the phenytoin half-life by 39% and decreased the phenytoin metabolic clearance rate by 27%. When giving these drugs concurrently, be alert for possible excessive phenytoin effect. Sulfonamides can displace methotrexate from plasma protein binding sites, thus increasing free methotrexate concentrations.

Drug/Laboratory Test Interactions: Bactrim, specifically the trimethoprim component, can interfere with a serum methotrexate assay as determined by the competitive binding protein technique (CBPA) when a bacterial dihydrofolate reductase is used as the binding protein. No interference occurs if methotrexate is measured by a radioimmunoassay (RIA). The presence of trimethoprim and sulfamethoxazole may also interfere with the Jaffe alkaline picrate reaction assay for creatinine, resulting in overestimations of about 10% in the range of normal values.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Carcinogenesis: Long-term studies in animals to evaluate carcinogenic potential not conducted with Bactrim. **Mutagenesis:** Bacterial mutagenic studies not performed with sulfamethoxazole and trimethoprim in combination. Trimethoprim demonstrated to be nonmutagenic in the Ames assay. No chromosomal damage observed in human leukocytes *in vitro* with sulfamethoxazole and trimethoprim alone or in combination; concentrations used exceeded blood levels of these compounds following therapy with Bactrim. Observations of leukocytes obtained from patients treated with Bactrim revealed no chromosomal abnormalities. **Impairment of Fertility:** No adverse effects on fertility or general reproductive performance observed in rats given oral dosages as high as 70 mg/kg/day trimethoprim plus 350 mg/kg/day sulfamethoxazole.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Trimethoprim and sulfamethoxazole may interfere with folic acid metabolism; use during pregnancy only if potential benefit justifies potential risk to fetus. Nonteratogenic Effects: See CONTRAINDICATIONS section.

Nursing Mothers: See CONTRAINDICATIONS section.

Pediatric Use: Not recommended for infants under two months (see INDICATIONS and CONTRAINDICATIONS sections).

ADVERSE REACTIONS: Most common are gastrointestinal disturbances (nausea, vomiting, anorexia) and allergic skin reactions (such as rash and urticaria). **FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS (SEE WARNINGS SECTION).**

Hematologic: Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, neutropenia, hemolytic anemia, megaloblastic anemia, hypoprothrombinemia, methemoglobinemia, eosinophilia. **Allergic Reactions:** Stevens-Johnson syndrome, toxic epidermal necrolysis, anaphylaxis, allergic myocarditis, erythema multiforme, exfoliative dermatitis, angioedema, drug fever, chills, Henoch-Schoenlein purpura, serum sickness-like syndrome, generalized allergic reactions, generalized skin eruptions, photosensitivity, conjunctival and scleral injection, pruritus, urticaria and rash. **Periarteritis nodosa** and systemic lupus erythematosus have been reported. **Gastrointestinal:** Hepatitis (including cholestatic jaundice and hepatic necrosis), elevation of serum transaminase and bilirubin, pseudomembranous enterocolitis, pancreatitis, stomatitis, glossitis, nausea, emesis, abdominal pain, diarrhea, anorexia. **Genitourinary:** Renal failure, interstitial nephritis, BUN and serum creatinine elevation, toxic nephrosis with oliguria and anuria, crystalluria. **Neurologic:** Aseptic meningitis, convulsions, peripheral neuritis, ataxia, vertigo, tinnitus, headache. **Psychiatric:** Hallucinations, depression, apathy, nervousness. **Endocrine:** Sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents; cross-sensitivity may exist. Diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. **Musculoskeletal:** Arthralgia, myalgia. **Miscellaneous:** Weakness, fatigue, insomnia.

DOSAGE AND ADMINISTRATION: Not recommended for use in infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN: Usual adult dosage for urinary tract infections is one DS tablet, two tablets or four teaspoonfuls (20 ml) b.i.d. for 10 to 14 days. Use identical daily dosage for 5 days for shigellosis. **Recommended dosage for children** with urinary tract infections or acute otitis media is 8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses every 12 hours for 10 days. Use identical daily dosage for 5 days for shigellosis. **Renal Impaired:** Creatinine clearance above 30 ml/min, give usual dosage; 15-30 ml/min, give one-half the usual regimen; below 15 ml/min, use not recommended.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS: Usual adult dosage is one DS tablet, two tablets or four teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS: Recommended dosage is 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

HOW SUPPLIED: DS (double strength) tablets (160 mg trimethoprim and 800 mg sulfamethoxazole)—bottles of 100, 250 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 20, tablets (80 mg trimethoprim and 400 mg sulfamethoxazole)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. **Pediatric Suspension** (40 mg trimethoprim and 200 mg sulfamethoxazole per teasp.)—bottles of 100 ml and 16 oz (1 pint). **Suspension** (40 mg trimethoprim and 200 mg sulfamethoxazole per teasp.)—bottles of 16 oz (1 pint).

STORE TABLETS AT 15°-30°C (59°-86°F) IN A DRY PLACE PROTECTED FROM LIGHT. STORE SUSPENSIONS AT 15°-30°C (59°-86°F) PROTECTED FROM LIGHT.

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THE CHANGING CHARACTER OF CORONARY ARTERY BYPASS GRAFTING

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Two hundred consecutive patients undergoing coronary artery bypass grafting (CABG) in 1985 are compared to 200 consecutive patients having CABG in 1980 and 1975. Patients undergoing CABG in 1985 were older, more hemodynamically impaired than in 1975 or 1980. Yet, current patients undergo more bypasses per operation with markedly improved survival.

The surgical treatment of coronary artery disease has undergone significant changes since its initial widespread application in the early 1970s. The Veterans Administration Cooperative Study,¹ the European Coronary Surgery Study Group,² and the CASS Randomized Trial³ have attempted to define individuals best suited for medical versus surgical therapy. While these three prospective studies did not reach the same conclusions, they focused surgical attention on the determinants for recommending surgical or medical therapy for the treatment of coronary artery disease.

This report does not deal with the indications for surgical therapy for coronary artery disease. Rather, it compares cohorts of patients referred at three- and five-year intervals for coronary artery surgery. In essence, this report reviews what a large university surgical center actually sees after the referring physicians have screened and determined which patients are suited for coronary artery operation. Cohorts of 200 patients operated upon in 1975, 1980, and 1985 are compared in order to determine their symptomatic and hemodynamic differences at the time of their presentation. Next, changes in operative techniques over the ten-year period are evaluated, and finally, the operative results of these 600 patients are reviewed.

Thus, setting aside the reasons for referral for cor-

onary artery bypass grafting (CABG), this report attempts to determine the effectiveness of CABG as it has evolved from 1975 through 1985.

METHODS AND MATERIALS

The first 200 consecutive patients undergoing solely CABG in 1975 were compared to the first 200 consecutive patients undergoing CABG in 1980, and again to 200 patients undergoing CABG in 1985. Any patient who underwent an associated cardiac procedure such as valve replacement or aortic surgery was excluded from these consecutive patient series. All patients undergoing coronary bypass surgery were included despite the stage of their presentation of disease. Specifically, the series includes "all comers" including individuals operated upon in the midst of myocardial infarctions, those requiring intra-aortic balloon pump support, as well as those admitted electively for bypass surgery. Preoperative evaluation included age, sex, and whether the CABG operation was elective or urgent.

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TABLE 1
Patient Profile

	1975	1980	1985
Patients	200	200	200
Age (years)	52.7 ± .62	57.0 ± .61	59.6 ± .87
Male/Female Ratio	177:23	170:30	155:45

The operation is termed elective if an individual is admitted from home on a prearranged date. An urgent operation is one in which the patient is transferred to our institution from another hospital directly or is considered too ill for discharge to an elective operative status following catheterization. New York Heart Association Class was determined for all patients. The pattern of angina pectoris was characterized as stable or unstable. Prior myocardial infarction was noted. The ejection fraction and the left ventricular end-diastolic pressure (LVEDP) were determined in all 600 patients prior to operation. The requirement for preoperative intra-aortic balloon pump support also was noted. All patients underwent preoperative catheterization and angiography. The number of diseased vessels in all patients was determined.

The operative reports were reviewed. The number of coronary bypass grafts was determined for each patient. In addition, the total time on cardiopulmonary bypass as well as the ischemic time induced by cross-clamp were determined on all patients.

Intermittent aortic cross-clamping at normothermia for the distal anastomoses was utilized in the 1975 cohort of patients. By 1980, a single period of aortic cross-clamping was used along with whole body hypothermia and crystalloid cardioplegia instilled at 4°C to arrest the heart.⁴ The 1985 cohort of patients similarly underwent a continuous period of aortic cross-clamping under hypothermic conditions but blood cardioplegia had replaced the clear cardioplegia. In addition, some patients in the 1985 cohort of patients received an aortic infusion of warm blood

cardioplegia just prior to the removal of the aortic cross-clamp. A bubble oxygenator was used in 1975, but a membrane oxygenator replaced it in the 1980 and 1985 groups.

All postoperative problems were recorded such as perioperative myocardial infarction, arrhythmias, postpericardiotomy syndrome, bleeding, infection, stroke, and renal and pulmonary complications. The requirement for intra-aortic balloon pump to be separated from cardiopulmonary bypass also was noted. Hospital death was defined as death during the operative hospitalization or death within 30 days of the operation, whichever was longer.

Postoperative followup was determined by letter or by a telephone call to the patient or the referring physician. The number of survivors was determined as well as the number of late postoperative myocardial infarctions. A carefully worded questionnaire was used to determine the New York Heart Association Class for all survivors of the operation.

Univariate association of factors was tested via the chi-square statistic, Fisher's exact probability test, and the student's t-test for unpaired sample means. Statistical analyses were done via the ABSTAT* statistical software package.

RESULTS

The 200 patients undergoing coronary artery bypass grafting in 1975 averaged 52.7 ± .62 years of age. In 1980, they averaged 57.0 ± .61 years, and in 1985, they

*Trademark of the Anderson-Bell Company.

TABLE 2
Preoperative Patient Profile

	1975	1980	1985
Patients	200	200	200
Elective CABG	69% (138)	60% (120)	54% (108)
Urgent CABG	31% (62)	40% (80)	46% (92)
New York Heart Association Classification	3.16 ± .05	2.90 ± .06	3.29 ± .07
Unstable Angina	73% (146)	94% (187)	87% (174)
Prior Myocardial Infarction	39% (77)	51% (101)	60% (119)
Ejection Fraction	59.9 ± 1.0%	54.1 ± 0.92%	50.0 ± 0.92%
LVEDP* mm Hg	9.92 ± .36	11.48 ± .44	12.58 ± .48
Preoperative IABP**	5% (10)	5% (9)	10% (19)
Number of Diseased Vessels	3.11 ± .07	3.13 ± .06	3.21 ± .04

*LVEDP: Left ventricular end-diastolic pressure.

**IABP: Intra-aortic balloon pump.

TABLE 3
Operative Patient Profile

	1975	1980	1985
Patients	200	200	200
Number of CABG	2.17 ± .07	2.87 ± .06	3.19 ± .06
Cardiopulmonary Bypass Time (min)	123 ± 3.0	102 ± 2.0	100 ± 2.2
Ischemic Time (min)	29.9 ± 1.2	55.0 ± 1.3	48.5 ± 1.4
Perioperative Myo- cardial Infarction	10% (19)	7% (14)	4% (8)
Intraoperative IABP*	4% (8)	2% (4)	6% (12)
Hospital Mortality	10% (19)	2% (3)	2% (4)

*IABP: Intra-aortic balloon pump.

TABLE 4
Postoperative Patient Profile

	1975	1980	1985
Patients	200	200	200
Total Followup	86% (171/200)	88% (175/200)	99% (196/200)
12-Month Mortality	2% (4/181)	0.5% (1/190)	2% (4/196)
Overall Mortality	21% (37/171)	5% (8/175)	4% (8/196)
Overall Postoperative Myocardial Infarction	9% (17/171)	2% (4/175)	2% (4/198)
Current New York Heart Association Classification	1.73 ± .12	1.43 ± 1.0	1.20 ± .06

averaged 59.6 ± .87 years of age. The male:female ratio in 1975 was 177:23; in 1980, the male:female ratio was 170:30; and in 1985, the male:female ratio was 155:45 (Table 1).

Preoperative evaluation. The preoperative symptomatic, hemodynamic, and functional data are recorded in Table 2. The comparison of the three cohorts of patients with *P* values is indicated in Table 5. The significant findings are that from 1975 to 1985, the number of patients requiring urgent coronary bypass significantly increased (*P*<.01); more patients presented with unstable angina in 1985 (*P*<.001); and more patients presented with prior myocardial infarction in 1985 compared to 1980 or 1975 (*P*<.001).

Similarly, the ejection fraction and LVEDP were significantly worse for patients undergoing coronary bypass surgery in 1980 and 1985 compared to 1975. The number of diseased vessels was not significantly different among the three cohorts of patients.

Operative Results. The number of bypasses per patient, the characteristics of cardiopulmonary bypass, and the hospital mortality results are indicated in Table 3. The comparison of the patients operated upon in the three periods is shown in Table 5. Over the ten-year period, the number of coronary bypass grafts per patient increased significantly from 2.2 per patient to 3.2 per patient in 1985. The overall cardiopulmonary bypass time decreased. The change in bypass time occurred between 1975 and 1980, with no significant difference since that time. The ischemic time in 1975

was not as long as that in 1980 or 1985. This most probably is due to the fact that intermittent cross-clamp was used in 1975 and continuous cross-clamp using cardioplegic protection was used in the last two groups. Perioperative myocardial infarction significantly decreased over the ten-year period. Requirement for intraoperative intra-aortic balloon pump support was variable but quite small in all three groups. The hospital mortality declined from 10 percent in 1975 to 2 percent in 1980 and 2 percent in 1985.

Postoperative Patient Followup. Followup was achieved in 86 percent of the patients from 1975, 88 percent of the patients in 1980, and 99 percent of the patients operated upon in 1985. The 12-month mortality was 2 percent in 1975, 0.5 percent in 1980, and 2 percent in 1985 (Table 4). The overall (early and late) mortality was 21 percent, 5 percent, and 4 percent, respectively. The overall postoperative myocardial infarction rate decreased significantly from 9 percent in 1975 to 2 percent in 1980 and 2 percent in 1985.

The current New York Heart Association symptomatic classification for patients alive who were operated on in 1975 is 1.73 versus 1.43 in 1980, and 1.2 in patients operated on in 1985. The *P* values from this data are summarized in Table 5.

DISCUSSION

In analyzing the data from 1975 versus 1985—the end of the ten-year spectrum of coronary artery bypass graft surgery—it becomes clear that we now are operat-

TABLE 5
Comparison of Data: 1975, 1980, and 1985

	<i>1975 versus 1980</i>	<i>1980 versus 1985</i>	<i>1975 versus 1985</i>
Preoperative Evaluation			
Age	52.7 vs 57.0 <i>P</i> <0.001	57.0 vs 59.6 <i>P</i> <0.02	52.7 vs 59.6 <i>P</i> <0.001
Male:Female Ratio	177 vs 170 <i>P</i> >0.30 NS	170 vs 155 <i>P</i> >0.05 NS	177 vs 155 <i>P</i> <0.01
Elective:Urgent Ratio	138 vs 120 <i>P</i> >0.05 NS	120 vs 108 <i>P</i> >0.20 NS	138 vs 108 <i>P</i> <0.01
New York Heart Association Classification	3.16 vs 2.90 <i>P</i> <0.01	2.90 vs 3.29 <i>P</i> <0.001	3.16 vs 3.29 <i>P</i> >0.10 NS
Unstable:Stable Angina Ratio	146 vs 187 <i>P</i> ≪0.001	187 vs 174 <i>P</i> <0.05	146 vs 174 <i>P</i> <0.001
Prior Myocardial Infarction	77 vs 101 <i>P</i> <0.01	101 vs 119 <i>P</i> >0.05 NS	77 vs 119 <i>P</i> ≪0.001
Risk Number	8.31 vs 9.57 <i>P</i> <0.01	9.57 vs 11.26 <i>P</i> <0.001	8.31 vs 11.26 <i>P</i> ≪0.001
Ejection Fraction	54.9 vs 54.1 <i>P</i> >0.20 NS	54.1 vs 50.0 <i>P</i> <0.01	54.9 vs 50.0 <i>P</i> <0.001
LVEDP*	9.92 vs 11.48 <i>P</i> <0.01	11.48 vs 12.58 <i>P</i> >0.05 NS	9.92 vs 12.58 <i>P</i> <0.001
Preoperative IABP**	10 vs 9 <i>P</i> >0.80 NS	9 vs 19 <i>P</i> =0.05	10 vs 19 <i>P</i> >0.05 NS
Number of Diseased Vessels	3.11 vs 3.13 <i>P</i> ≧0.20 NS	3.13 vs 3.21 <i>P</i> >0.20 NS	3.11 vs 3.21 <i>P</i> >0.20 NS
Operative Evaluation			
Number of CABG	2.17 vs 2.87 <i>P</i> ≪0.001	2.87 vs 3.19 <i>P</i> <0.001	2.17 vs 3.19 <i>P</i> ≪0.001
Pump Time	123 vs 102 <i>P</i> <0.001	102 vs 100 <i>P</i> >0.20 NS	123 vs 100 <i>P</i> <0.001
Aortic Clamp Time	29.9 vs 55.0 <i>P</i> ≪0.001	55.0 vs 48.5 <i>P</i> <0.001	29.9 vs 48.5 <i>P</i> ≪0.001
Perioperative Myocardial Infarction	10% vs 7% <i>P</i> >0.30 NS	7% vs 4% <i>P</i> >0.10 NS	10% vs 4% <i>P</i> <0.05
Intraoperative IABP**	4% vs 2% <i>P</i> >0.20 NS	2% vs 6% <i>P</i> <0.05	4% vs 6% <i>P</i> >0.30 NS
Hospital Mortality	10% vs 2% <i>P</i> <0.001	2% vs 2% NS	10% vs 2% <i>P</i> <0.01
Postoperative Evaluation			
12-Month Mortality	2% vs 0.5% <i>P</i> >0.16 NS	0.5% vs 2% <i>P</i> >0.18 NS	2% vs 2% NS
Overall Mortality	21% vs 5% <i>P</i> ≪0.001	5% vs 5% NS	21% vs 5% <i>P</i> ≪0.001
Postoperative Myocardial Infarction	9% vs 2% <i>P</i> <0.01	2% vs 2% NS	9% vs 2% <i>P</i> <0.01
Current New York Heart Association Classification	1.73 vs 1.43 <i>P</i> >0.05 NS	1.43 vs 1.20 <i>P</i> =0.05	1.73 vs 1.20 <i>P</i> <0.001

*LVEDP: Left ventricular end-diastolic pressure.

**IABP: Intra-aortic balloon pump.

ing upon significantly older individuals and significantly more females than we did in the past. At the time of presentation, patients operated upon in 1985 had far more urgent symptoms and poorer functional capacity as determined by the New York Heart Association Classification. Prior myocardial infarction is much more common in 1985 compared to 1975. This is reflected in the 1985 cohort of patients having a lower ejection fraction, a higher left ventricular end-diastolic pressure (LVEDP), and a more frequent requirement for preoperative intra-aortic balloon pump support. Interestingly, the number of diseased vessels per patient demonstrated at the time of preoperative angiography is not significantly different now versus ten years ago.

Complete revascularization was the rule in 1985 compared to 1975, and this is supported by the significant increase in the number of grafts per patient in 1985 of 3.19 versus 2.17 in 1975. Despite the increased number of grafts, the increased skill gained with experience has decreased the routine pump time significantly. This has resulted in a significantly decreased incidence of perioperative myocardial infarctions. Importantly, the hospital mortality has decreased significantly in the ten-year period probably related to improved skill and better myocardial preservation.

Twelve-month postoperative followup also has shown a decrease in late deaths over the ten-year period, and significant improvement in the postoperative New York Heart Association Class for patients operated upon in 1985 versus 1975.

Data suggest that in 1985 patients referred for CABG have more advanced disease and exhibit greater hemodynamic dysfunction. Nevertheless, the evolution of surgical techniques and surgical ability has more than overcome these differences and has resulted in markedly improved results for the 1985 cohort compared to the 1980 or 1975 cohort.

There are several possible explanations for the worsening of the presenting clinical picture. Whole new classes of drugs such as the calcium channel blockers and the ACE inhibitors have delayed the requirement for surgical therapy in many individuals. Of interest has been the widespread application of percutaneous transluminal coronary angioplasty. Some patients who in 1975 or 1980 would have been referred for CABG now are being treated with angioplasty, thus eliminating these usually better risk patients from the 1985 cohort of patients presenting for CABG. The true impact of angioplasty still is unknown.

The fact that current surgical coronary bypass techniques have decreased morbidity and mortality certainly is not a new observation. Multiple studies have documented improved morbidity and mortality over the past ten years.⁵⁻²⁷

Cosgrove and colleagues reviewed the trends in surgical mortality from primary myocardial revascularization from over 24,000 patients operated upon at the Cleveland Clinic.⁴ In decreasing order of significance, the risk factors for primary revascularization were emergency operation, congestive heart failure, left mainstem disease, female gender, history of congestive heart failure, advancing age, normothermic arrest, number of grafts, poor ventricular function, and incomplete revascularization. While Cosgrove and the

Cleveland Clinic Group have nicely indicated who the higher risk patients are for coronary bypass surgery, it is of interest that as surgeons, we have very little control over who actually presents as surgical candidates for coronary bypass surgery. More precisely, while the patients referred to us surely need operation, in fact, we have no control over a larger, presumably lower risk, population of potential surgical candidates who are not referred for operation. Thus, while we read the large prospective randomized studies with interest, in actuality, they do not define the kinds of patients upon whom we now are operating.

Nonetheless, while we are now seeing patients for operation at a more impaired level of myocardial performance, we are able to achieve better intraoperative and postoperative results than we achieved ten years ago.

CONCLUSIONS

Patients presenting for coronary bypass operation in 1985 are significantly older, require more urgent operation, and have a greater degree of left ventricular impairment than patients presenting for CABG in 1975 or even 1980.

Significantly more coronary bypass grafts per patient, in the setting of improved intraoperative myocardial preservation techniques, are performed now versus 1975 or 1980.

Short-term as well as long-term morbidity and mortality significantly are improved in the 1985 cohort as compared to the earlier cohorts, despite the fact that the 1985 cohort is more symptomatically and hemodynamically impaired.

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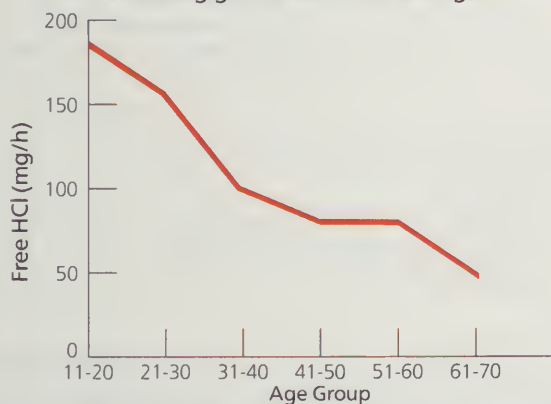
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Pregnancy: Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients, adverse effects were reported in 121 (4.7%). Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED

CARAFATE (sucralfate) 1-gm pink tablets are supplied in bottles of 100 and in Unit Dose Identification Paks of 100. The tablets are embossed with MARION/1712.

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SALVAGE PTCA IN PATIENTS WHO ARE NOT CANDIDATES FOR CORONARY SURGERY

RICHARD D. GOULAH, M.D., JONATHAN E. GOLDSTEIN, M.D., JACOB I. HAFT, M.D., NEWARK*

Because PTCA routinely is performed with surgical backup, patients with significant noncoronary disease that contraindicates coronary bypass surgery are excluded. We performed successfully PTCA in two patients with preinfarction angina who were not candidates for bypass surgery.

Percutaneous transluminal coronary angioplasty (PTCA) is a well-recognized procedure which can be utilized as an alternative to coronary artery bypass graft (CABG) surgery in certain patients.¹⁻³ This procedure most often is performed with surgical backup so the patient who suffers unexpected damage to the vessel during PTCA can undergo immediate coronary artery bypass graft surgery to prevent extensive myocardial damage.¹ It generally is felt that only those patients who are candidates for coronary bypass surgery should be allowed to undergo PTCA. Thus, any patients with coronary artery disease and extremely poor left ventricular function and patients with significant noncardiac disease that would make the surgical course difficult or dangerous, usually are excluded from PTCA. The following report demonstrates the utilization of PTCA in two patients with preinfarction angina and significant noncoronary artery disease who were not candidates for surgery.

CASE REPORT 1

A 76-year-old white male was admitted to Saint Michael's Medical Center for intraperitoneal chemotherapy for colon carcinoma with liver metastases. In 1984, evaluation of anemia revealed colon carcinoma, which was resected with end-to-end anastomosis.

Thirty years prior to his present admission, he developed renal infection with transient renal shut down. Shortly after the diagnosis of colon carcinoma was made, he began to develop renal failure and was found to have staghorn calculi. A nephrostomy tube was put in place; however, renal failure increased and he was treated with chronic hemodialysis. Recently, liver metastases were detected by computed tomography scan. He was hospitalized for intraperitoneal chemotherapy with 5 fluorouracil (FU). One month prior to this admission, he initially developed chest pain described as "indigestion" and relieved with eructation. Subsequently, he was pain-free until one week after this admission when he awakened at 2 A.M. with similar chest pain, described as "indigestion," but it radiated to both arms, lasted ten minutes, and was relieved with one sublingual nitroglycerin tablet (NTG). The patient fell asleep but awakened again with chest pain one hour later and again relieved with nitroglycerin. The next day, after eating his lunch and while walking to the bathroom, he developed chest pain which responded to NTG. A cardiology consultation was requested.

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This patient had no previous history of coronary artery disease, hypertension, diabetes, hypercholesterolemia; the family history of coronary artery disease was negative. He denied the use of tobacco and alcohol. There was no history of paroxysmal nocturnal dyspnea, orthopnea, ankle edema, syncope, near-syncope, or congestive heart failure. Hospital medications included Amphojel®, temazepam, and 5FU; he had received no cardiotoxic medications. Physical examination revealed a well-developed, well-nourished, fully oriented 76-year-old white male in no acute distress. Vital signs were within normal limits: BP = 110/60; P = 80/min and regular; temperature = 98°; and respirations = 16/min. The head, eyes, ears, nose, and throat (HEENT) examination was within normal limits. The neck was supple with no jugular venous distention, thyromegaly, or lymphadenopathy. A right carotid bruit was audible. Lungs were clear. The cardiac point of maximum impulse was in the 5th intercostal space at the mid-clavicular line; the first and second heart sounds were normal and there were no murmurs or gallop rhythm. The abdomen was soft, flat, and nontender with no organomegaly. A nephrostomy tube was in place and an intraperitoneal chemotherapy catheter was present in the lower left abdomen. There was no clubbing, cyanosis, or edema of the lower limbs and peripheral pulses were present. Neurological examination was normal. Electrocardiogram revealed normal sinus rhythm with a rate of 90 and zero axis. There was very minimal ST elevation in the inferior leads with insignificant Q waves. Each bout of chest pain was associated with 2 to 3 mm ST elevation in the inferior leads with tall peaked T waves noted in the anterior leads that reverted to normal with relief of pain. Serum creatine phosphokinase levels remained normal throughout all of the episodes of chest pain. Serum Na⁺, K⁺, and Cl⁻ were normal; BUN was 74 and creatine was 6.5 mg/dl. His serum bicarbonate was 20.8. Hemoglobin was 9.6 gm/d, hematocrit 36.8, and white cell count 13,000. Prothrombin time (PT) and partial thromboplastin time (PTT) were normal. Chest x-ray revealed moderate scoliosis and degeneration of the thoracic spine and stable increased interstitial markings in the right lung base, as compared to previous chest x-rays with a normal cardiac silhouette.

Transdermal nitroglycerin and oral nifedipine, 10 mg every eight hours, were started. On the evening of hospital day 8, the patient again developed retrosternal chest pain; he was transferred to the coronary care unit and treated with intravenous nitroglycerin with prompt control of pain. The following day, we performed coronary arteriography, which revealed hypokinesis of the inferobasal area of the left ventricle. The right coronary artery (RCA) had a 90 percent stenosis in the mid-region; the left circumflex had a 40 percent stenosis in the proximal area, and the left anterior descending artery had a proximal 40 percent lesion. Because of these findings and the ST changes associated with chest pain, we felt that this patient's symptoms were due to the RCA lesion and that he was a potential candidate for balloon angioplasty. However, because of his colon carcinoma with metastases to the liver and chronic renal failure requiring hemodialysis, we felt that surgery could not be justified, and if he went through PTCA, it would be with no surgical

backup. After fully discussing this with the patient and his family and explaining all of the risks, the patient agreed to undergo PTCA. On hospital day 10, the patient underwent successful dilatation of the right coronary artery to approximately 90 percent of luminal size. After an additional 3-day asymptomatic stay in the coronary care unit, he was transferred to a regular care unit where he continued his intraperitoneal chemotherapy and his hemodialysis. The patient was discharged from the hospital after 20 days for outpatient care by his oncologist, nephrologist, and cardiologist.

CASE REPORT 2

An 82-year-old white female was in her usual state of health until three weeks prior to admission when she experienced retrosternal chest pressure radiating to the neck and to the shoulders. It occurred while shoveling snow, but there was no shortness of breath, diaphoresis, nausea, vomiting, lightheadedness, or palpitations. The pain resolved after 30 minutes; she took two aspirin and went to sleep. On awakening the following morning, she experienced similar chest pain with minimal exertion in the kitchen without any associated symptomatology. The pain lasted 10 minutes and was relieved with rest. She was admitted to a community hospital where electrocardiogram revealed inverted T waves in the inferior and lateral leads; cardiac enzymes were normal. While in the hospital, the patient experienced several episodes of chest pain at rest with no further changes on the electrocardiogram and no changes in the cardiac enzymes. The patient was transferred to Saint Michael's Medical Center for coronary arteriography. Medications included heparin, metoprolol, nifedipine, and sublingual nitroglycerin. There was no history of diabetes, hypertension, previous myocardial infarction, hypercholesterolemia, rheumatic fever, heart murmurs, tobacco use, or family history of coronary artery disease. Physical examination revealed a very fragile, fully alert, 82-year-old white female in no acute distress. Vital signs were normal and physical examination was unremarkable except for an S4 gallop rhythm. Coronary arteriography revealed a 99 percent proximal stenosis in the left circumflex artery, a 50 percent stenosis in the mid-region of the right coronary artery, and minimal intraluminal disease in the left anterior descending coronary artery (LAD). The left ventriculogram was normal.

The patient refused to be considered for coronary bypass surgery, but we felt she was an excellent candidate for PTCA. After we explained the risks to the patient, she agreed to PTCA without surgical backup. On hospital day 3, coronary angioplasty with dilatation of the RCA lesion to a near normal intraluminal diameter was performed. After an uneventful three-day stay in the coronary care unit, the patient was transferred to a regular room. When discharged, we prescribed aspirin, dipyridamole, and nifedipine.

DISCUSSION

Patients similar to those reported here are commonly seen in the practice of cardiology and pose an important therapeutic dilemma. The first patient had severe single vessel disease with preinfarction angina that ordinarily would have led to his undergoing PTCA.

However, he also had two additional noncardiac diseases, metastatic colon carcinoma and hemodialysis dependent renal failure, which would make emergency coronary bypass surgery more dangerous and would prolong the recovery period. His expected life span obviously was limited. We felt that coronary bypass surgery should not be performed on this 76-year-old man under any circumstance and the patient and his family agreed. He was willing to accept the risk of PTCA without surgical backup, however, and we felt justified in offering this alternative. The result was excellent.

The second patient was a fragile elderly lady with severe unstable angina and an obvious culprit coronary lesion in an optimum position for angioplasty. Although coronary bypass surgery has been performed successfully in 82-year-old patients, complications, prolonged morbidity, and a poor prognosis for rehabilitation to the premorbid state occur much more frequently in such patients so bypass surgery rarely is pursued in these patients. When this patient refused surgery, we felt that insistence on surgical backup was not justifiable in this patient. After explaining the risks, we performed successful angioplasty with her agreement. We did have a surgeon and blood on hand anyway in case she changed her mind in the event a symptomatic total coronary occlusion occurred.⁴

The incidence of emergency surgery following elective PTCA is approximately 5 to 8 percent; an additional 5 to 10 percent of patients undergo elective surgery because of inability to cross or dilate the coronary lesion.^{1,4} Because of this, elective PTCA is performed only with surgical backup on standby.¹ In both of our patients, the clear-cut symptoms of severely unstable angina appeared to be related to the anatomical findings on coronary arteriography; because of their instability, thallium stress testing appeared dangerous and not warranted. Both patients had received therapy with nitrates, beta blockers, and calcium channel blockers and both remained symptomatic. In both patients, the risk of infarction or death due to their cor-

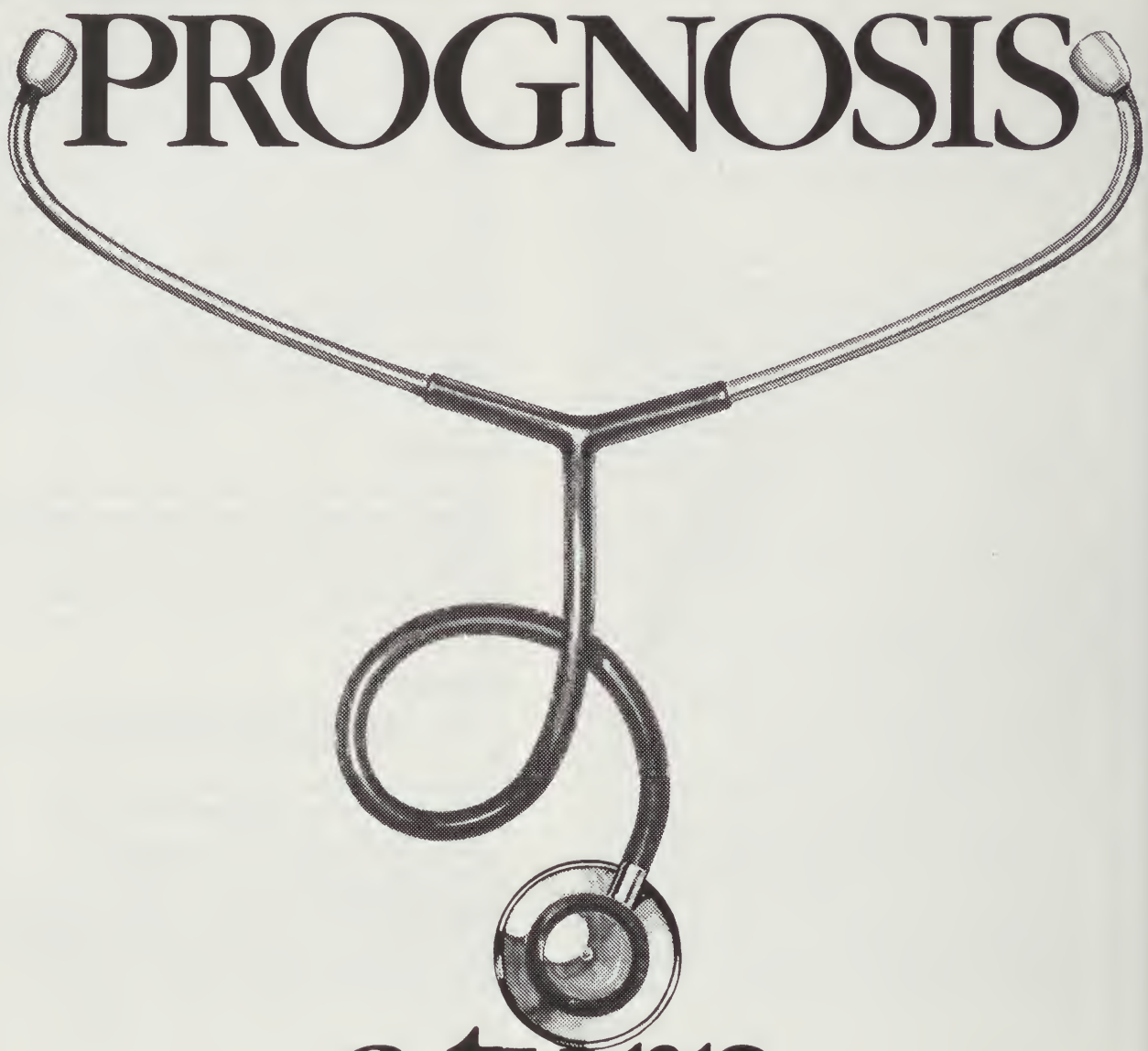
onary lesions appeared to far exceed the risks of the procedure, even without surgical backup. Hence, with the patient's informed consent, we performed angioplasty. The medicolegal implications of offering PTCA without surgical backup remain unclear. The risks were discussed with the patients and their families and the possibility of death was described frankly. We felt that the alternative, withholding PTCA because surgery was too risky in the first patient or withholding PTCA unless we could convince the second patient to accept a surgical procedure to which she and her family were adamantly opposed, was not in the patient's best interest although it was the safest route for the physicians to take. As noted, with our second patient in whom surgery was not absolutely contraindicated, we typed and crossmatched blood and had a surgeon stand by in the event that the patient changed her mind at the last moment if an emergency occurred.

CONCLUSION

In the future, we expect more patients similar to ours to present themselves to internists and cardiologists. Physicians and patients should realize that PTCA is a modality of therapy that may be offered to informed patients who are not candidates for coronary artery bypass grafting.

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CASE REPORT: VAGINOGRAPHY FOR COLOVAGINAL FISTULA

DONALD ROTHMAN, M.D., AND PAUL DEDICK, M.D., RED BANK*

Colovaginal fistulas are rare and sometimes difficult to demonstrate. Barium enema often fails to demonstrate the pathology and may be dangerous. Endoscopy fails, but vaginography may visualize enteric fistulas. Radiologic procedures and pathology are described.

Colovaginal fistulas are rare.¹⁻⁴ The pathological etiologies are many and varied. Demonstration of the tract can tax the ingenuity of the radiographer.^{5,6} Visualization of the tract is important for surgical planning. Two cases of sigmoid-vaginal fistulas are presented.

CASE REPORT 1

In December 1983, a 63-year-old woman developed a vaginal discharge which was unresponsive to oral antibiotics. At age 39, she had a two-stage hysterectomy for a pelvic infection and stated that one operation took 14 hours. Vaginal examination disclosed purulent drainage from an opening high in the vagina. Sigmoidoscopy to 20 cm revealed spasm, but no lesions. There was a calculus demonstrated in the left kidney on an otherwise normal intravenous pyelogram. Sigmoid and descending colon diverticulosis was noted on barium enema (Figure 1) and eight days later the patient noted barium and stool coming from the vagina. Vaginography revealed a sigmoid-vaginal fistula (Figure 2). On February 20, exploratory laparotomy disclosed extensive adhesions, cirrhosis of the liver, and a fistula to the vagina from sigmoid diverticulitis. The sigmoid colon and fistula were resected, the vaginal defect was closed, end-sigmoid colostomy was created, and the rectum was stapled by a Hart-

mann's procedure. The patient was discharged two weeks later after recovery from a prolonged ileus. On May 8, 1984, the sigmoid was reanastomosed. She was discharged on May 20, 1984, and did well thereafter.

CASE REPORT 2

A 56-year-old diabetic female was first seen in April 1984, for right leg pain of one year's duration. On the basis of physical examination and Doppler indices, a diagnosis of aortoiliac arteriosclerosis was made. She had a moderate disability until May 1986 when intolerable ischemic pain necessitated aortography and aortobifemoral bypass. End-of-graft to side-of-vessel anastomoses were used and the inferior mesenteric artery was not ligated. Postoperative pain, distention, and diarrhea were at first attributed to antibiotic-induced colitis, but poor response to treatment prompted flexible sigmoidoscopy; biopsy indicated ischemic colitis. She was treated with cecostomy, total parenteral nutrition, and supportive measures, and was discharged one month after the original operation. Diarrhea and vague abdominal pain persisted. Outpatient sigmoidoscopy showed hyperemia, but no ulcerations. Several days later, stool was expelled from the

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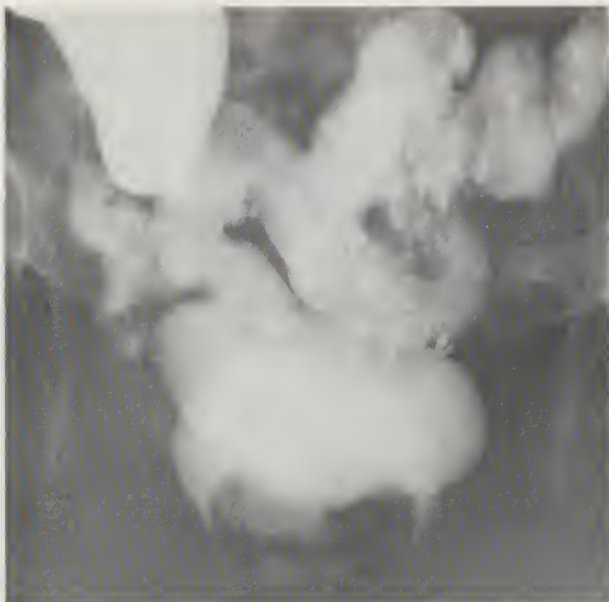


Figure 1—Extensive diverticulosis on barium enema with no fistula demonstrated.



Figure 2—Fistulous tract (curved arrow) running from vagina (filled with Renografin® via catheter) (straight arrow) to sigmoid diverticulum.

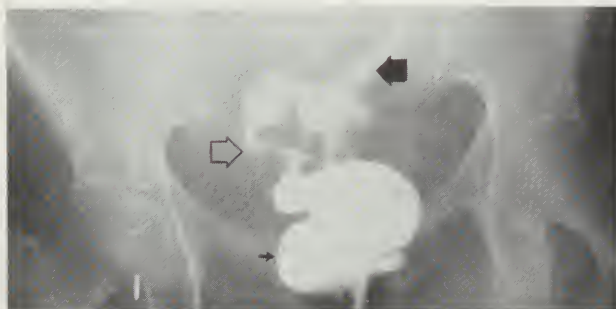


Figure 3—Contrast via catheter in vagina (small arrow) fills fistula (open arrow) and communicates to narrow left colon (large black arrow).

vagina. Vaginography revealed a sigmoid-vaginal fistula (Figure 3). On September 26, exploratory laparotomy revealed the left colon to be rigid, necrotic, and imbedded in the retroperitoneum. It was only possible to do an end transverse colostomy and drainage, but the vaginal fistula could not be identified. Partial slough of the colostomy occurred, but this did not require revision and it functioned satisfactorily with irrigations. The patient has recovered; she eats well, gains weight, and walks without pain.

DISCUSSION

Colonic fistulas are well-described entities and

usually involve the bladder and sigmoid (colosigmoid fistula), but the skin, kidney, pleural space, and other portions of the gastrointestinal tract and vagina can be involved as well.^{3,4,7-9} Pathological etiologies are myriad: diverticulitis, cancer, trauma, abscesses, surgical injury, radiation, and inflammatory bowel disease.

Of course, demonstration of the fistula is important for the surgical correction. Multiple fistulas may exist and the portion(s) of the gastrointestinal tract involved obviously is significant to the surgeon. Localization of the fistula by endoscopy can be disappointing since the opening often is small, hidden in a deep edematous area, or difficult and dangerous to reach because of intestinal narrowing and distortion. Barium enema x-ray often fails to demonstrate the fistula as in the first case because the tract is small, the barium too thick, and not enough pressure can be exerted to fill the channel. Overlapping bowel loops may obscure the fistula. On occasion, the barium enema given to the patient may be contraindicated, dangerous, or not well tolerated.

Vaginography has been described but it is not well known. Our technique is as follows: A No. 24 or No. 26 French 30 cc balloon Foley catheter is inserted into the vagina. Following inflation of the balloon with air, gentle traction is placed on the catheter to assure occlusion of the introitus. Following this, contrast material (Renografin® 60) is introduced through the catheter under fluoroscopic guidance. Thirty ml of contrast material was adequate to demonstrate the abnormality in both cases. The vagina initially was filled with the patient in the supine position and then oblique and lateral projections were obtained to define the exact site of the fistula. The visible mucosal pattern of the intestine was adequate to define whether large or small bowel was involved. An overhead film confirmed the fluoroscopic findings. There were no complications.

Advantages of this method are the simplicity of execution, the ability of the liquid contrast to enter narrow tracts, the sterility of the medium to negate the potential hazard of barium peritonitis, and the avoidance of overlapping bowel encountered with contrast enemas. The use of the Foley balloon to obtain a good seal may be the reason for success here.

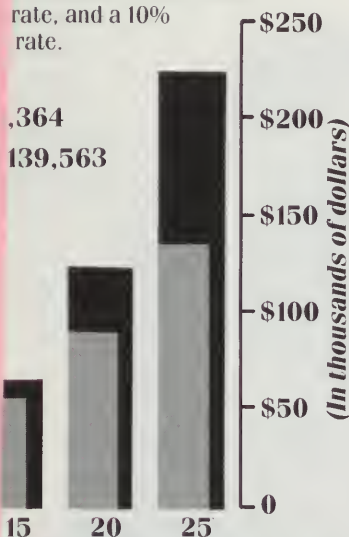
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OPINION: A FEASIBLE SOLUTION

ARTHUR BERNSTEIN, M.D., SOUTH ORANGE*

The author contends that physicians must always remain advocates for patients and give them the best possible medical care—whether they are paid adequately or not.

In a recent article in *NEW JERSEY MEDICINE*, I pointed out the fact that patients did not like to pay for being sick. They wanted their treatment to be cost-free since it was an "act of God" that made them ill.¹

The advent of Blue Cross and Blue Shield, as well as indemnity insurance companies, fostered this attitude. Patients who had coverage no longer wanted to be treated at home. They wanted to go to the hospital because "they were entitled" by dint of the premiums they paid.

The physicians also were paid by the insurance mechanism when the patient was hospitalized, so they lost nothing by this arrangement. That made everything cozy. (This was the beginning of cognitive versus invasive fee differentials). The advent of Medicare also fostered this type of thinking, so all was seemingly a wonderful world for patient and doctor.

But soon the premiums began to rise for Blue Cross and Blue Shield and for the indemnity companies, while their payments to the physician went down for economic reasons. The same situation developed with the federal plans. Thus started the curse of billing for balances, or at times the development of "artful billing" to make up for the cuts. This is when the schism between patient and physician truly began to widen and the patient-doctor relationship began to crumble.

Is this new? No, it is not! We have all seen the famous painting "The Four Stages of the Doctor and Patient" by da Vinci: When the patient is very sick, the doctor is a god. When the patient is getting better, the doctor is an angel. When the patient is well, the doctor is a man. And when the patient receives the bill, the doctor is a devil.

Nothing has changed in this regard except that we were lulled into a sense of security and patient acceptance when our bills were paid by a third party and the patient felt the care was free.

Alas, the honeymoon is over!

Now, what do we do? We join all kinds of groups to protect our rights to "fee for service."

When we lived in small communities or in closely knit neighborhoods, we knew our patients as friends and neighbors, but that is all gone in our larger cities with their scattered suburbs. Thus, we have lost our close rapport with patients and have become suspect like any other "business" or "dealership."

How do we overcome this feeling of "I'm entitled to health care by premiums and I don't need to pay any more." Look at what support for this idea did in Massachusetts. It is obvious that this is the underlying prob-

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lem. But, we must always remain an advocate for our patients, no matter what PRO tells us, or any of the third-party payors set as criteria for fees. We must give the best possible medical care whether we are paid adequately or not at all. We must protect the patient and treat the illness no matter what the rules or fees, or lack thereof, may be. Only then will we be respected and admired as a profession once more.

Will a massive public relations campaign help? I don't think so, based on my discussions with my patients and many others with whom I have met.

Will a relative value scale that the AMA is working on be workable? Yes, it will be if the physicians accept it and if insurance premiums cover it so that there is no additional out-of-pocket expense for the patient. This gives the impression of free medical care which, as I've pointed out, is the goal of the patient.

It is this same desire for "free" medical care that has led to national health insurance in many countries, followed in time by two-tier medicine. In these countries, the physician works for the "system" for eight hours and then has a private practice in the evening for those who are desirous of more personal attention and are willing to pay for it. This seems to work in some places, but do we want that here?

What do we want? "Fee for service" is a nice slogan but what does it really mean? Fifty years ago, when I started in practice, we had fee for service—50¢ for an office visit and \$1 for a house call. Deliveries were \$25. Very often we were not paid at all because people could not afford even these fees. We didn't send out bills for collection or sue them. They were our neighbors! The milieu has changed, and attitudes have changed, but we have not deigned to change our thinking because we liked the "good old days and ways." Let us be realistic and accept the fact that we must change and find acceptable ways to charge for our services, realizing that our patients do not want to pay.

Uwe Reinhardt, Professor of Economics at Princeton University, has made some suggestions; each time I hear him, he is espousing a new method, so the answer

is obviously not a simple one.

Now that I have listed the symptoms and signs of this deep-seated illness and some of the suggested therapies, let us get together and put our collective brains to work and come up with an innovative method that will cure all of our patients and ourselves.^{2,3}

I will make a few suggestions. All government-run plans wind up with a top-heavy expensive bureaucracy. This is not a feasible plan to keep costs down, except at the expense of the patient or the physician or both. All insurance plans, whether they be Blue Cross, indemnity plans, or HMOs, must make a profit to exist, so they too must exist at the expense of the patient or physician, or both.

The answer with which we are left is a well-planned relative value scale agreed upon by all concerned and run by a minimal amount of bureaucratic management. The AMA and others are involved now with the formulation of such a scale. Consideration must be given for balancing so-called cognitive services with invasive technology. In this system, with reasonable premiums, the patients and the physicians once again can establish the rapport that is necessary for good medical management at an equitable cost. It must be a system that Dr. Daniel J. McCarty calls a "zero sum proposition."⁴ In this way, the patient will have minimal premiums and the savings would accrue to patients and physicians, not to bureaucratic machines.

As Thomas Huxley said "If all but you have lost their heads, better take another look."

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OPINION: PLACING A VALUE ON YOUR MEDICAL PRACTICE

DAVID J. SHUFFLER, HASBROUCK HEIGHTS*

An established, active medical practice is a valuable asset and has a far-reaching impact on the current financial status of a physician as well as future financial and professional goals.

Of all the business transactions a physician encounters during his or her professional career, none seems to cause more confusion or create more uncertainty and anguish than establishing the fair market value of a medical practice.

For the past 20 years, medical practices rarely were bought or sold. The reason was simple: medical expenditures, adjusted for inflation, grew more rapidly than the number of physicians. Each doctor practiced in a world of expanding resources. A new doctor merely opened a practice and patients soon arrived.

Now, spurred by the rapid increase in number of physicians, which is outpacing the growth in medical expenditures, there is a growing market for medical practices. An established, active medical practice is a valuable asset and has a far-reaching impact on the current financial status of a physician as well as future financial and professional goals.

Although the effect of a devalued practice most often is felt by a retiring doctor, all practitioners should be aware of the fair market value of their practices. Personal reasons as well as practice management considerations dictate that a practice appraisal be conducted every five to seven years.

Arriving at an appropriate value for a medical practice is a complex process and an inexact science; rarely can it be made with indisputable precision. The

ramifications cut across contract and tax law, medicine, accounting, marketing, and appraisal.

Calculating the value of the intangible assets of a medical practice is the most critical step in determining total value. Intangibles, which include good will, patient records, and restrictive covenant, could account for as much as 70 to 85 percent of total value. Two variables determine intangible value: the reliability of current earnings and the predictability of future earnings. Market value is the inter-relationship between these variables and it is measured by the capitalized value of cash flow.

Although market value is predicated upon the reliability of current earnings and predictability of future earnings, other factors such as the quality of the revenue-producing patient base and dynamics of the catchment area as well as the fixed cost of conducting practice are important considerations. Perhaps the most significant factor in the valuation formula is the risk of attrition which is a function of the interaction of the quality of the patient base, the medical specialty and maldistribution. In order to minimize attrition, it is essential that the seller work with the buyer during the transition period to retain the patients of record

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and maintain services rendered.

The sale of a medical practice is not one sale, but a series of subsales. The sale proceeds must be allocated among the individual assets of the practice with gain or loss computed accordingly. Tax implications should be reviewed carefully with experts because individual income tax strategies as well as the provisions of the tax code of 1986 could alter the after tax proceeds of the sale. Real estate is a separate transaction from the sale of the practice.

In order to maximize market value, a physician must maintain an active, viable practice. Physicians need to plan for the future, work hard, continue to seek and attract new patients, maintain existing equipment, and invest in new technology; a physician also must maintain an informed staff.

The economic changes that have taken place make practice valuation more and more important. The more realistic an appraisal, the more useful the figures will be. Practice valuation is basic to nearly every aspect of

your overall practice and financial planning.

The Medical Society of New Jersey and the Academy of Medicine of New Jersey in cooperation with First Jersey National Bank, held a seminar entitled, "Techniques for Measuring the Value of a Medical Practice," in October 1987. As indicated by the participant evaluations, the workshop was a resounding success. Karl K. Klinges, M.D., stated "I had the opportunity of attending the program covering the value of a medical practice. The program was outstanding with a very practical nuts and bolts presentation made by Mr. David Shuffler of the First Jersey National Bank, on evaluating the greatest asset most of us will ever have. In this age of medicine, I strongly urge all physicians, regardless of their age, to attend future seminars."

This program will be repeated in the near future. Audiocassettes of the program and the workbook/manual are available. Order forms can be obtained by calling Genie Cox at the Academy of Medicine of New Jersey, 609/896-1717.

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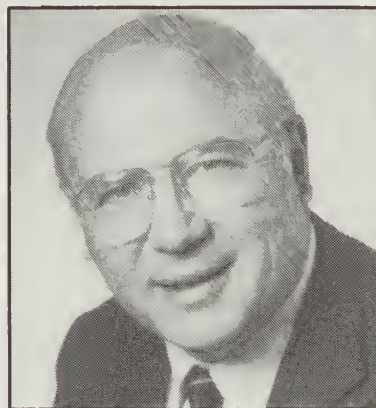
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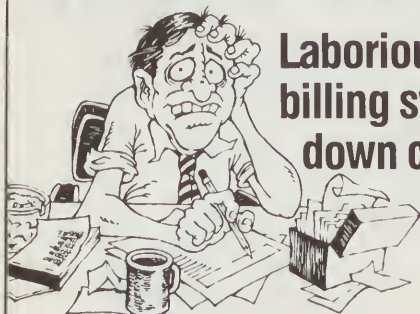
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Trustees' Minutes; UMDNJ Notes; Legislative Bulletin; Physicians Seeking Location in New Jersey

Trustees' Minutes January 17, 1988

A regular meeting of the Board of Trustees was held on January 17, 1988, at the Executive Offices in Lawrenceville. A detailed report is on file with the secretary of your county society. A summary of significant actions follows:

Report of the President . . .

(1) Executive Committee Meeting with Legislative Representatives . . . Was announced that a meeting of the Executive Committee was held with Assemblyman Harold L. Colburn and Speaker Chuck Hardwick to discuss the SCI report, AIDS, Medicaid, tort reform, physician assistants, physical therapists, and nurse practitioners.

(2) Future Meetings . . . Noted the following future meetings: (a) Task Force on AIDS on January 27, 1988; (b) the Committee on Medicaid with Commissioner of Human Services Dr. Drew Altman on January 20, 1988, and Drs. Carnes, Formica, and Malta, Edward F. Meara, III, Clark W. Martin, Mr. Maressa, and Senate President John F. Russo on February 3, 1988; (c) joint meeting of the Executive Committee of MSNJ and New Jersey Hospital Association on January 20, 1988; (d) Drs. Carnes, Formica, and Mineur, Joseph W. Katz, Mr. Maressa, and Chief Justice Wilentz on February 3, 1988, to discuss the proposed amendment of

Rule 4:21, the qualification of medical experts in trial courts, and the discipline of attorneys; and Drs. Carnes, Formica, and Malta, Edward F. Meara, III, Clark W. Martin, Mr. Maressa, and Senate President John F. Russo on February 3, 1988.

Report of Executive Director . . .

(1) MSNJ Paid Membership . . . Noted paid membership as of December 31, 1987, was 7,567.

(2) December 1987 Financial Statements . . . Noted financial statements were unavailable, and would be ready for review in February.

(3) Independent Legal Opinion Regarding PACE . . . Received a report from Gross & Novak, with an independent opinion regarding legal ramifications of the PACE and Medallion programs offered by Blue Cross and Blue Shield.

(4) SCI Update . . . Noted that proposed legislation is being drafted by Judge Stern in the matter of the SCI Report on the Impaired Physicians Program.

(5) Reinsurance Association Surcharge . . . Voted unanimously to support and continue MSNJ's position that those physicians who created the losses of the Reinsurance Association (1977-1982) should pay the annual 4 percent surcharge being proposed by the Commissioner of Insurance.

NJ Hospital Association . . . Voted to continue its present position in support of the NJHA, and to refer the entire issue to the Council on Medical Services for study and advice. Note: MSNJ endorsed the position of NJHA for an increase in the base rate of reimbursement to hospitals to provide quality care for the citizens of New Jersey and agreed to contact the Hospital Rate-Setting Commission.

New Business . . .

(1) Massachusetts Medical Society Council Resolution . . . Defeated a motion to send a copy of the Massachusetts Resolution to the members of the legislature; the Resolution stated, "The Massachusetts Medical Society considers the Commonwealth of Massachusetts an undesirable location in which to practice." Note: The reason for the Resolution was that the over-regulation of medical practice in Massachusetts is driving quality health care

and the physicians who provide it, out of state.

(2) Boyd versus St. Joseph's Hospital . . . Noted that the vote was not in favor of appearing as amicus curiae in this case; the case centers around the rule of the hospital's medical board that physicians must become board certified by their primary specialty board within four years to maintain hospital privileges.

UMDNJ Notes

**Stanley S. Bergen, Jr., M.D.
President**

Two years ago, Governor Thomas Kean urged UMDNJ to become one of the top 25 academic health science centers in the United States. His challenge immediately became our rally cry, and the top 25 effort has developed into the foundation for all of our institutional initiatives.

We have studied the matter extensively during the past two years, and those studies continue. We have developed a much clearer understanding of the characteristics of a first-class health sciences institution, and we've begun to determine what we must do to develop those characteristics. In January, during my annual State of the University address, I was able to announce for the first time our best estimate of the pricetag for success in the Top 25 effort.

We believe we will need some \$650 million over the next decade—over and above our current budget—if we are to provide New Jersey with a world-class facility for health professions education, health service delivery, and biomedical research. This money would come from state appropriations, federal grants, fundraising efforts in the private sector, and faculty practice and other self-generated income. But the money must begin to flow soon, or the window of opportunity will close.

The linchpin of any first-rate research university is a large and prestigious faculty. Much of the new money will go toward vastly increasing the size of our faculty, and toward recruiting some of the most prominent scientists in the world to our campuses.

The need for more faculty creates a need for more space. As mundane as it may sound, physical space could be the single most fundamen-

tal impediment to our top 25 aspirations. Space right now is a crisis issue for our present faculty, to say nothing of the adverse impact on our critical future recruitment efforts. It is the numbers of faculty; the importance and diversity of their work; their reputations; and the significant dollars that both they and their programs attract that will enable the kind of system we are talking about to fall into place and to develop a degree of self-reliance.

UMDNJ's recruitment effort during the past two years has begun to "snowball," and a number of prominent individuals have expressed interest in following their colleagues to the University. It is a shame that we cannot now welcome them because of space limitations.

In specific terms, here is how we propose to invest that \$650 million:

- Hire at least 400 new additional faculty members and 700 support personnel, such as technicians and graduate fellows, over the next decade.

- Fill 15 key leadership positions at the dean and department chair levels with individuals who have national and international reputations.

- Construct new research towers and clinical services buildings, amounting to some 400,000 square feet, at the Newark and Piscataway campuses.

- Continue to develop and refine specialized "centers of excellence" in such areas as biotechnology, environmental and occupational medicine, liver transplantation and related diseases, cancer, kidney disease, Alzheimer's and other ailments of aging, reproductive medicine, and heart disease.

Making it to top 25, however, will require more than dollars. The University will need enhanced governance and flexibility to remove impediments that prevent us from seizing opportunities and undertaking new challenges in a timely manner; and recognition of the special roles and missions of the University's core teaching hospitals—and certain other affiliate hospitals—through rate relief for medical education and special consideration for certificate of need and other regulatory processes.

We intend to pursue the Top 25 agenda as vigorously as we know how for the UMDNJ.

Legislative Bulletin

S-1276-Contillo—Tobacco Sales to Minors. Prohibits the sale of tobacco and tobacco products to minors. **Approved.**

S-2137-McManimon—Health Planning. Creates a "local health planning" system to operate the certificate of need apparatus. The agencies would be funded by a special tax on hospitals. **Active Opposition;** MSNJ is opposed to governmental mandated health planning.

S-2387-DiFrancesco—Temporary Disability. Protects pregnant workers and others by providing mandatory job guarantees and health benefits for up to 26 weeks in a given year. **No Action.**

S-2392-DiFrancesco—Temporary Disability. Provides that parents of newly born, adopted, or seriously ill children will be entitled to leave from employment and guarantees employment security. Protected leave would be 26 weeks in a 24-month period. **No Action.**

S-2424-Codey—Pharmacy (same as A-2559). Prohibits certain health care institutions from conducting a retail pharmacy. **Active Opposition,** in accordance with Board of Trustees' actions (April 12, 1987). This bill is anti-consumer and detrimental to the future efforts of hospitals and physicians to diversify services in order to meet cost containment goals.

S-2960-Ewing—AIDS. Requires persons suspected of venereal disease to submit to HLTIV-III tests; requires applicants for marriage licenses to be tested and the physician to notify them in writing of the results on a form developed by the Department of Health; requires physicians to certify that they have tested applicants and notified them of the results. **Action Deferred,** pending further information from MSNJ's AIDS/HIV Task Force.

S-3009-Dalton—Emergency 911. Provides for planning and implementation of a 911 system throughout the state. **Conditional Approval,** pending amendment to the bill that would transfer the financing mechanism from community business phone users to the state government.

S-3013-McNamara—Medicaid. Expands the medically needy program to cover inpatient care. **Approved.**

S-3019-Pallone—Ocean Environment. Calls for the Department of Health and the Department of Environmental Protection to undertake a health impact study on New Jersey coastal waters; appropriates \$1 million for the study. **Approved.**

S-3164-Lesniak—Medical Licensure. Deletes the requirement that physicians attend at least two years of college. **Disapproved,** because the existing statute that applies to educational requirements in New Jersey should not be weakened.

S-3170-Dorsey—Political Contributions (same as A-4374). Limits PAC contributions to \$2,500 per candidate per calendar year. **No Action.**

S-3177-Rand—Prescription Drugs. Prohibits mail order prescription drugs in state employee programs. **Conditional Approval,** pending amendment to the bill that would prohibit mail order drug

dispensing unless they comply with all New Jersey drug dispensing regulations.

S-3233-Ewing—AIDS. Requires inmates in correctional institutions to be tested for AIDS. **Action Deferred,** pending further information from the AIDS/HIV Task Force.

S-3256-Cardinale—Healthy Lifestyles. Requires health insurers to give financial incentives for healthy lifestyles under insurance contracts and to offer wellness plans approved by the Commissioner of Insurance and Commissioner of Health. **Conditional Approval,** pending amendment to include periodic health care examinations.

S-3284-Zimmer—Emergency Medical Technicians. Permits emergency medical technicians (EMT) certified by the Commissioner of Health as an EMT-D to perform cardiac defibrillation. **Active Support.**

S-3288-Bassano—Audiologists. Deletes the requirement that audiologists and speech therapists must pass a national examination. **Action Deferred,** pending further information from the New Jersey Academy of Ophthalmology and Otolaryngology.

S-3302-Feldman—Surrogate Parenting. Establishes a commission to study surrogate parenting. **Conditional Approval,** pending inclusion of MSNJ-appointed physician on the Commission.

S-3320-McManimon—Nursing Supply. Creates a commission to study the nursing supply problem; no medical representation is included. **Conditional Approval,** pending inclusion of physician on Commission.

S-3352-VanWagner—Civil Immunity. Grants civil immunity to counselors and psychotherapists for disclosing a patient's potential for violence in certain situations. **Conditional Approval,** pending inclusion of physician in psychotherapy section of bill.

S-3381-Zane—Auto Insurance. Provides for certain amendments to the no-fault law. Establishes a medical fee schedule that incorporates the fees of 90 percent of the practitioners within a given region. **No Action.**

S-3390-Rand—Southern New Jersey Children's Hospital. Designates Cooper Hospital as the "Southern New Jersey Children's Hospital" provided a majority of the acute care hospitals providing inpatient pediatric care in southern New Jersey agree to refer to Cooper. (This bill substituted by A-4073.) **Approved** (letter to Governor and sponsor of the bill, regarding obvious defect in DRG system.)

S-3414-McManimon—AIDS. Requires that funeral directors be notified in writing if a patient had a communicable disease which requires that precautions be taken. **Conditional Approval,** pending amendment to assure confidentiality of information by the funeral director.

S-3429-Dalton—Medical Fee Schedule (Auto Insurance). Provides that the Commissioner of Insurance shall promulgate a fee schedule at the 90th percentile. The schedules are to be reviewed biannually. **No Action.**

S-3475-Ambrosio—Recovery of Burial Expenses. Provides that

noneconomic damages in the wrongful death of a minor shall be limited to \$100,000. **Action Deferred**, pending further information from the Medical Inter-Insurance Exchange.

S-3482—AIDS. Requires the Department of Health to adopt rules to assure that hospitals accept their fair share of patients with AIDS or ARC. **No Action.**

S-3498—Cardinale—Osteoporosis (same as A-3707). Creates a 15-member Commission to study services to patients with osteoporosis; five of the members shall be health care professionals. **No Action.**

S-3500—McManimon—Disability Determinations (same as A-4465). Allows psychologists to certify disability. **Active Opposition**, the determination of disability certification is a medical decision.

S-3510—Dalton—Emergency Medical Services. Extends the Emergency Medical Services Study Commission another four months; the Commission in its first phase report has recommended a state-wide 911 system. **Approved.**

S-3518—Haines—HMO. Provides that if an HMO and a contracting health care facility do not renew their contract, it shall remain in force for four months following the contract expiration date in order to allow enrollees the opportunity for normal transition. **Conditional Approval**, pending an amendment to provide that the same notification be forwarded to providers as well as enrollees.

S-3633—Lipman—"Wellness". Requires health insurers to offer wellness incentives. **No Action.**

S-3651—DiFrancesco—Involuntary Commitments. Assures patients in short-term psychiatric facilities and screening services certain civil rights. **Action Deferred**, pending further information from MSNJ's Council on Mental Health.

S-3682—Gormley—Medical Waste Disposal. Imposes strict liability on hospitals and health care facilities for the damages caused by the discharge of waste into the ocean or fresh waters of the state. **Action Deferred**, pending further information from MSNJ's Council on Public Health and the Medical Inter-Insurance Exchange of New Jersey concerning the joint and several liability referred to in the bill statement.

S-3696—McManimon—Local Health Planning. Appropriates \$650,000 to fund local health planning. **Active Opposition**, mandated planning has not proved effective and should not be continued. Eleven states plus the federal government have deleted it.

A-2559—Felice—Pharmacy (same as S-2424). Prohibits institutions from operating retail pharmacies within 1,500 feet of their facility. **Active Opposition**, in accordance with Board of Trustees' actions (April 12, 1987). This bill is anticonsumer and detrimental to the future efforts of hospitals and physicians to diversify services in order to meet cost containment goals.

A-2682—Stuhltrager—Minors. Prohibits the sale of tobacco to minors. **Approved.**

A-3079—Paterniti—Temporary Disability. Provides that jobs of persons on

temporary disability must be protected for 26 weeks. **Disapproved**, this bill would have a significant adverse impact on small businesses.

A-3081—Cattrillo—Temporary Leave. Provides that positions of parents of seriously ill children may take protected leave of up to 26 weeks within a two-year period. **No Action.**

A-3683—Martin—Nursing Education. Directs Rutgers to establish a doctoral program in nursing. **Disapproved**, the trustees of the University should determine what degrees should be offered.

A-3707—Paterniti—Osteoporosis (same as S-3498). Establishes a commission (15 members) to compile and analyze data on osteoporosis, develop educational programs, and assist local health agencies in public education. **No Action.**

A-3711—Zecker—No Fault. Amends the no-fault law in several areas; requires carriers to conduct utilization review and to engage in managed care. **Disapproved**, third-party carriers are denying patients access to needed care; this legislation would aggravate that situation.

A-3719—Cooper—Withholding or Withdrawing Treatment in Terminal Illness. Allows competent adults to issue a directive that provides they shall not be artificially sustained during a terminal

condition. No definition is provided for terminal condition. **Action Deferred**, pending report of the Governor's Commission on Biomedical Ethics.

A-3724—Cattrillo—AIDS. Requires the Department of Health to institute a mobile educational program on AIDS for intravenous drug users. **Action Deferred**, pending further information from MSNJ's HIV/AIDS Task Force.

A-3725—Singer—Child Abuse. Establishes a child abuse diagnostic center in southern New Jersey. **Approved.**

A-3744—Ogden—Communicable Disease. Requires health care facilities to notify first aid, ambulance, or rescue squads that the patient they are transporting has a communicable disease when that fact is known to the facility. **Approved.**

A-3751—Loveys—Structured Payments in Tort (same as A-4615). Requires structured payments when future damages exceed \$200,000 by means of an annuity contract. **Active Support.**

A-3754—Doyle—Emergency Services. Requires volunteer emergency personnel to be certified either through the State First Aid Council or the Department of Health. **Approved.**

A-3777—Colburn—Certificate of Need (CON). Allows hospitals to undertake outpatient projects costing no more than

MEDICAL SOCIETY OF NEW JERSEY ANNUAL MEETING

April 27-May 1, 1988

Sheraton Meadowlands Hotel
East Rutherford

Proposed Daily Schedule

Wednesday, April 27, 1988

3:30 p.m.—Board of Trustees' Meeting

Thursday, April 28, 1988

9:00 a.m.—Registration Opens
9:00 a.m.—Message Center Opens
2:00 p.m.—House of Delegates
3:30 p.m.—Reference Committees

Friday, April 29, 1988

8:00 a.m.—Registration Opens
8:00 a.m.—Message Center Opens
8:30 a.m.—Exhibits Open
9:00 a.m.—House of Delegates (election)
12:00 noon—Golden Merit Award Ceremony followed by Reception
2:30 p.m.—Reference Committees
5:00 p.m.—JEMPAC Political Forum
5:45 p.m.—JEMPAC Wine and Cheese Reception

Saturday, April 30, 1988

8:00 a.m.—Registration Opens
8:00 a.m.—Message Center Opens
8:30 a.m.—Exhibits Open
9:00 a.m.—House of Delegates
1:30 p.m.—House of Delegates
6:00 p.m.—Inaugural Reception followed by Inaugural Dinner

Sunday, May 1, 1988

8:00 a.m.—Registration Opens
8:00 a.m.—Message Center Opens
8:30 a.m.—Program on one topic of major interest to the physician
1:00 p.m.—Board of Trustees' Meeting

\$2,000,000 without obtaining a certificate of need. **Active Support.**

A-3801-Kline—AIDS (Health Insurance). Prohibits the denial of insurance to persons with AIDS. **Action Deferred,** pending further information from MSNJ's HIV/AIDS Task Force.

A-3817-Kline—AIDS (Funeral Directors). Requires doctors, nurses, or the medical examiner to notify the funeral director in writing if the decedent had or was suspected of suffering from a communicable disease. **Conditional Approval,** pending amendment to assure confidentiality of information by the funeral director; refer to MSNJ's HIV/AIDS Task Force.

A-3865-Kosco—Prosthetists and Orthotists. Licenses and regulates prosthetists and orthotists through a multidisciplinary professional board with the Division of Professional Boards. **Disapproved,** there is no indication that public interest will be served by licensing these technicians.

A-3882-Moran—Prescription Drugs (same as S-3177). Prohibits mail order prescription drugs in any state benefits program for public employees. **Conditional Approval,** pending amendment to the bill that would prohibit mail order drug dispensing unless they comply with all New Jersey drug dispensing regulations.

A-3933-Felice—Medicaid. Increases fees for professional health services to Medicaid recipients by 10 percent. **Conditional Approval;** Medicaid fees are an embarrassment and should be raised to the level of Medicare.

A-3935-Singer—Medicare. Requires the Commissioner of Health to study the senior medical courtesy program and to file a report by January 1, 1988. **No Action.**

A-3948-Kline—AIDS Reporting. Requires that patients with positive HTLV III be reported to the Department of Health within 72 hours. The Department shall institute contact tracing. All information is to be confidential. **Action Deferred,** pending further information from MSNJ's HIV/AIDS Task Force.

A-3965-Pelly—Impaired Professionals. Directs the Boards responsible for licensing certain but not all health professionals to institute impaired professional programs. Professional societies would contract with the respective boards to administer the program. There are no details regarding qualifications of personnel or funding. **No Action.**

A-3995-Gargiulo—Suicide (Elderly). Creates a 13-member commission to study the problem of suicide among the elderly. **Disapproved,** there are other sectors of our Society that have a suicide rate higher than the elderly—to be meaningful, the study should include all ages.

A-4001-Collins—Nursing Supply (same as S-3320). Creates a commission to study the nursing supply problem; does not include physician representation. **Conditional Approval,** pending inclusion of physician on Commission.

A-4013-Otlowski—Mental Health. Assures persons receiving treatment on

an involuntary basis in either a screening service or short-term facility of the same rights as patients who have been involuntarily committed to state or county psychiatric facilities. **Action Deferred,** pending further information from MSNJ's Council on Mental Health.

A-4043-Albohn—Audiologists. Deletes the requirement that audiologists and speech pathologists must pass a national examination. **Action Deferred,** pending further information from the New Jersey Academy of Ophthalmology and Otolaryngology.

A-4069-Kern—AIDS. Provides that anyone with AIDS who knows of their infection and commits an act of sexual penetration is guilty of a crime of the third degree. **Action Deferred,** pending further information from MSNJ's HIV/AIDS Task Force.

A-4073-Bryant—Southern New Jersey Children's Hospital (same as S-3390). Designates Cooper Hospital as the "Southern New Jersey Children's Hospital" provided a majority of the acute care hospitals providing inpatient pediatric care in southern New Jersey agree to refer to Cooper. (**Law c.299 (1987).**)

A-4119-Zecker—County Medical Examiners. Requires the state to finance the county medical examiner system. **No Action.**

A-4138-Kavanaugh—Surrogate Parenting. Prohibits the payment of money for surrogate parenting expenses. **No Action.**

A-4161-Kavanaugh—Alcoholism and Drug Abuse. Creates a Governor's Council on Alcoholism and Drug Abuse. The Council will be the single state agency for alcohol and drug abuse; coordinate all state educational programs; develop and implement a master plan for treatment, prevention, research, and education. The Council will be in but not "of" the Department of Health. **Action Deferred,** pending further information from MSNJ's Committee on Drug and Alcohol Abuse; refer to MSNJ's HIV/AIDS Task Force.

A-4171-Kern—Council on Alcoholism and Drug Abuse. Similar to but not identical to A-4161. Does not reorganize the current agencies in state government as does A-4161. **Action Deferred,** pending further information from MSNJ's Committee on Drug and Alcohol Abuse. Refer to MSNJ's HIV/AIDS Task Force.

A-4182-Deverin—Medicaid. Extends Medicaid benefits for one year for employed patients after they have left Aid to Families with Dependent Children (AFDC) eligibility. (**Law c.283(1987).**)

A-4249-Villane—Environment. Requires the state government to study the health effects of chlorinated sewage in coastal waters. **Approved.**

A-4316-Randall—Adolescent Drug and Alcohol Abuse. Requires the Commissioner of Health to establish a 15-member task force to study and make recommendations regarding regulations for drug and alcohol treatment programs for adolescents. **Action Deferred,** pending further information from MSNJ's Committee on Drug and Alcohol Abuse.

A-4334-Colburn—HMO Contracts

with Health Care Facilities. Provides that in the event that an HMO and a general hospital or other health care facility with which the HMO has a contract to provide services to its enrollees, are unable to agree on the terms of a new contract upon the expiration of the current contract, the health care facility and the HMO shall continue to abide by the terms of that contract for a period of four months from the date of expiration of the contract, during which time an enrollee of that HMO who has been receiving services from the health care facility under the terms of the previously existing contract may terminate his enrollment in the HMO and purchase health care benefits from another provider or insurance carrier. **Conditional Approval,** pending an amendment to provide that the same notification be forwarded to providers as well as enrollees.

A-4361-Kline—AIDS. Makes it a crime of the fourth degree for state employees to make an unauthorized disclosure of AIDS reports which have been submitted to the Department of Health. **Action Deferred,** pending further information on unauthorized disclosures.

A-4374-Donovan—Political Contributions (same as S-3170). Limits PAC contributions to \$2,500 per candidate per calendar year. **No Action.**

A-4432-Zecker—Civil Immunity. Permits certain nonprofit corporations to extend immunity to trustees, directors, officers, members, or employees when exercising judgment or discretion. **Approved.**

A-4435-Palaia—Emergency Medical Services (EMS). Appropriates \$1,500,000 to fund a statewide EMS network. **Approved.**

A-4465-Penn—Psychologists. Permits psychologists to certify disability under the temporary disability benefits law. **Active Opposition,** the determination of disability certification is a medical decision.

A-4466-Loveys—Joint and Several Liability. Eliminates joint and several liability except for environmental torts. **Active Support.**

A-4484-Rafferty—Collateral Sources of Income. Requires that collateral sources other than workers' compensation or life insurance shall be offset in personal injury actions. **No Action.**

A-4497-Villane—Medical Waste. Amends the hazardous waste act to include medical waste. **Action Deferred,** pending further information from MSNJ's Council on Public Health.

A-4515-Kern—Health Planning. Appropriates \$650,000 to fund local health planning. **Active Opposition,** mandated planning has not proved effective and should not be continued. Eleven states plus the federal government have deleted it.

A-4551-Deverin—Medicaid Fiscal Intermediaries. Provides that health service corporations and dental service corporations can qualify as intermediaries under Medicaid. **Approved.**

A-4615-Loveys—Structured Payments (same as A-3751). Provides for structured payments of future damages exceeding \$200,000. **Active Support.**

AR-141-Singer—Senior Medical Courtesy Program. Commends the Union and Ocean County Medical Societies for their senior medical courtesy programs. **Active Support.**

AR-143-Farragher—Medicare Fees. Requests Congress to raise fees to doctors participating in Medicare. **Active Support.**

AR-156-Kalik—Medicare — Catastrophic Illness. Requests Congress to provide Medicare recipients with catastrophic illness coverage. **Active Support.**

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Daniel O'Brien, M.D., 12 Beech Dr., Brunswick, ME 04011. Liege (Belgium) 1975. Board certified. Group, partnership, solo. Available.

ENDOCRINOLOGY—Alex Stewart Stagnaro-Green, M.D., 228 Voorhis Ave., River Edge, NJ 07661. Mount Sinai 1983. Also, internal medicine. Board eligible. Board certified (IM). Partnership, group, solo. Available July 1988.

FAMILY MEDICINE—William B. Glenn, D.O., 2 Raintree Way, Havelock, NC 28532. Philadelphia College 1980. Board certified. Group, partnership, solo. Available July 1988.

GASTROENTEROLOGY—Joel H. Kurtz, M.D., 2600 Netherland Ave., Apt. 2811, Riverdale, NY 10463. UMDNJ 1983. Board eligible. Partnership or group. Available July 1988.

HEMATOLOGY—Marta Meyers, M.D., 128 Hempstead Ct., Madison, NJ 07940. Medical College of Pennsylvania 1981. Also, internal medicine. Board certified. Group or partnership. Available.

INTERNAL MEDICINE—Robert P. Beswick, M.D., 2316 W. Cortez St., Chicago, IL 60622. Illinois 1981. Board certified. Group, partnership, clinic, industry. Available.

Glenn A. Dubov, M.D., 75-36 Bell Blvd., Apt. 2A, Bayside, NY 11364. Chicago 1983. Board certified. Also, nephrology. Group or partnership. Available July 1988.

Kathy Rosen Kerr, M.D., 318 Perrine Ave., Piscataway, NJ 08854. UMDNJ 1984. Also, pediatrics. Board eligible. Partnership or small group. Available July 1988.

Daniel R. Massarelli, M.D., 98 Longfellow Rd., Worcester, MA 01602. Georgetown 1985. Board eligible. Group, partnership, solo. Available September 1988.

Marta Meyers, M.D., 128 Hempstead Ct., Madison, NJ 07940. Medical College of Pennsylvania 1981. Also, hematology. Board certified. Group or partnership. Available.

Leilani L. Nixon, M.D., 1175 Gail Dr., Buffalo Grove, IL 60089. Illinois 1985. Board eligible. Partnership or solo. Available July 1988.

Sarva Daman Singh, M.D., 26 Carlson Ct., Closter, NJ 07624. Agra (India) 1978. Board eligible. Group or partnership. Available March 1988.

Samuel J. Stepanow, M.D., 430 W. Browning Rd., Apt. S-5, Bellmawr, NJ 08031. Hahnemann 1985. Board eligible. Group or partnership. Available July 1988.

Darius Sypek, M.D., 154 Oakwood Ave., Apt. 3, Cliffside Park, NJ 07019. Medical Academy (Poland) 1984. Board eligible. Group. Available July 1988.

Alex Stewart Stagnaro-Green, M.D., 228 Voorhis Ave., River Edge, NJ 07661. Mount Sinai 1983. Also, endocrinology. Board certified. Board eligible (ENDOCRIN). Partnership, group, solo. Available July 1988.

NEPHROLOGY—Glenn A. Dubov, M.D., 75-36 Bell Blvd., Bayside, NY 11364. Chicago 1983. Also, internal medicine. Board certified (IM). Group or partnership. Available July 1988.

OPHTHALMOLOGY—James Scott Lewis, M.D., 531 Sprague Rd.,

Narberth, PA 19072. Jefferson 1982. Group, partnership, solo. Available.

ORTHOPEDIC SURGERY—Richard Lebovitz, M.D., 707 Abbott St., Highland Park, NJ 08904. Downstate 1979. Board eligible. Partnership or solo. Available.

PEDIATRICS—Sheth Amit, M.D., 1305 E. 18 St., Brooklyn, NY 11230. N.H.L. Municipal (India) 1982. Board eligible. Group, partnership, solo. Available July 1988.

Meera Gupta, M.D., 57 Lawrence Dr., Berkeley Heights, NJ 07922. Nehru Medical College (India) 1977. Board eligible. Group or partnership. Available.

Kathy Rosen Kerr, M.D., 318 Perrine Ave., Piscataway, NJ 08854. UMDNJ 1984. Also, internal medicine. Board eligible. Partnership or small group. Available July 1988.

RADIOLOGY—Charles Saniewski, M.D., 9261 E. Bay Harbor Dr., #8, Bay Harbor, FL 33154. Rome 1983. Board eligible. Group or partnership. Available July 1988.

SURGERY—Victor B. Lebedovych, M.D., 211 S. Crapo St., Mt. Pleasant, MI. Michigan 1968. Board certified. Partnership or association. Available.

Ramiro Requena, M.D., Interfaith Medical Center, 555 Prospect Place, Brooklyn, NY 11238. Bolivia 1966. Board certified. Group, partnership, solo. Available.

UROLOGY—Charles Dorfman, M.D., 3313 Amherst Rd., Erie, PA 16506. Universidad Central del Este (Mexico) 1980. Board eligible. Group or partnership. Available July 1988.

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Category: (Please check one)

☐ Member, MSNJ

☐ Subscriber, NJ Medicine

☐ Other _____

Name _____

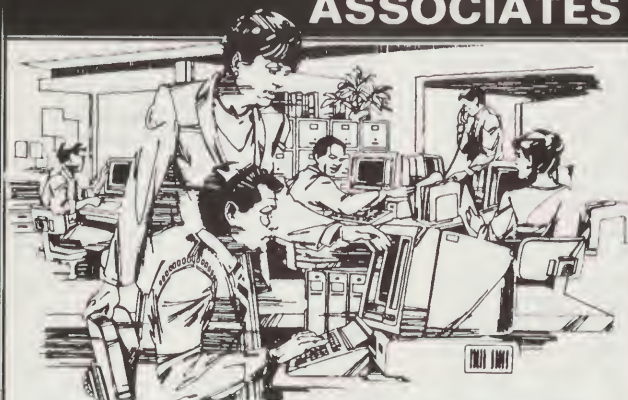
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JULY 1987 / VOL 9 NO 7

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- Endometrial Cancer: Causes and Patient Evaluation
- Pain Management in Primary Care
- Controlling Side Effects of Antipsychotic Drugs, Part 2: Extrapyramidal Symptoms
- ◀ Osteoporosis, Part 2: Prevention and Treatment

KEEPING CURRENT

Assessing Impairment of Elderly Hospitalized Patients
Routine Radiological Testing for Respiratory Illness
Using Ultrasound to Detect Hip Abnormalities
Diagnosing Bone Infection Under Pressure Sores
Slowing Progression of Diabetic Nephropathy
Behavioral Disorders Among Children of Alcoholic Fathers
Catheter-Related Septic Central Venous Thrombosis

Withdrawing Patients From Antihypertensive Drug Therapy
Cesarean Section and Infant Survival
Preventing Neonatal Group B Streptococcal Disease
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Urinary Tract Infections Among Uncircumcised Infants
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Surgical Management of Chronic Intestinal Ischemia
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SPECIAL FEATURE

Willingway: A Fellowship in Alcoholism and Drug Addiction

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HEADQUARTERS HOTEL**

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Meadowlands Hotel**

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**222nd ANNUAL MEETING
MEDICAL SOCIETY OF NEW JERSEY
Thursday, April 28, to Sunday, May 1, 1988**

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LOCATION MAP

SHERATON MEADOWLANDS HOTEL

Sheraton Plaza Drive—Two Meadowlands Plaza—East Rutherford, NJ 07073
Tel: (201) 896-0500

How to get to the Sheraton Meadowlands

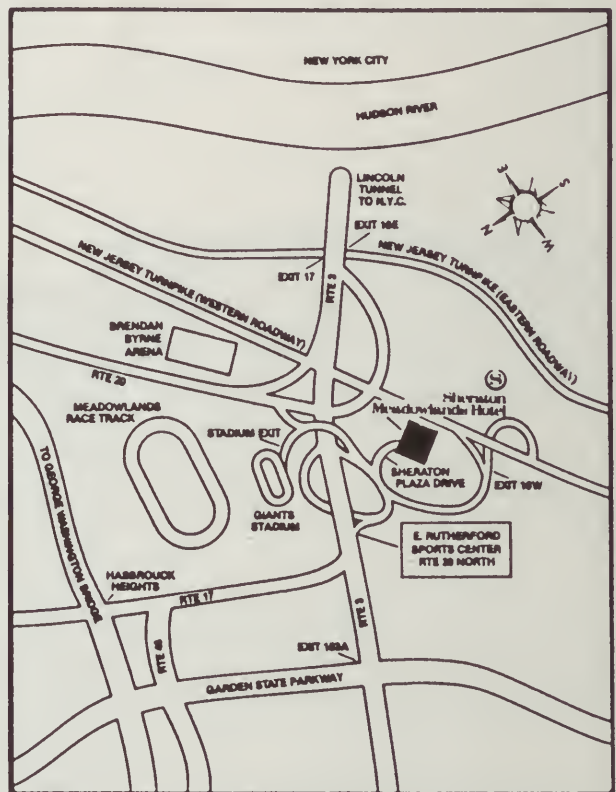
From New York via Lincoln Tunnel: Route 3 W to Sheraton Plaza Drive exit; follow signs to hotel.

From New Jersey Turnpike (N or S): Exit 16 W; follow signs to Route 3 E; stay on service road and follow signs for Sheraton Plaza Drive.

From New York via G. W. Bridge: Take I-95 (N.J. Turnpike) S; exit 16 W and follow as above.

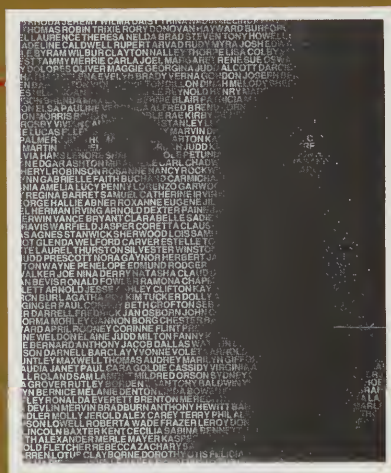
From Garden State Parkway (N or S): Exit 153A to Route 3 E to Route 20 N (Arena) exit; follow signs for Sheraton Plaza Drive.

From Route 17 (N or S): Exit Route 3 E and follow as above.



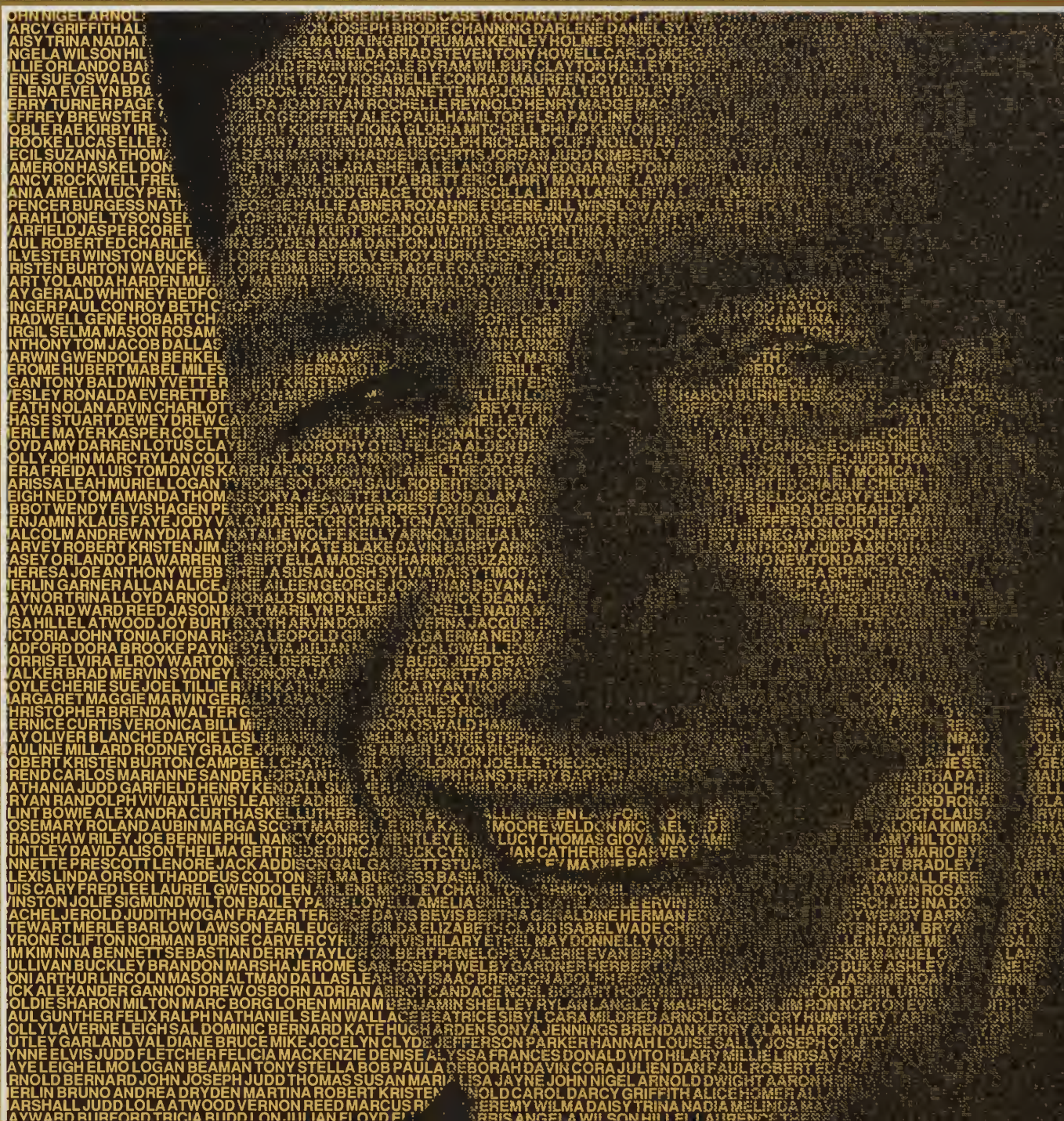
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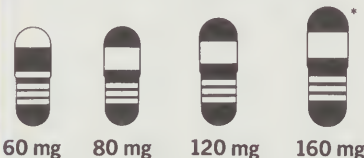
Please see next page for brief summary of prescribing information.

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL[®] LA brand of propranolol hydrochloride (Long Acting Capsules)

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. Inderal is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by Inderal, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

Inderal LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with Inderal LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of Inderal Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

Inderal LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to Inderal LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, Inderal LA has been therapeutically equivalent to the same mg dose of conventional Inderal as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. Inderal LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. **Hypertension:** Inderal LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. Inderal LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: Inderal LA is indicated for the long-term management of patients with angina pectoris.

Migraine: Inderal LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: Inderal LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. Inderal LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. Inderal is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with Inderal.

WARNINGS. **CARDIAC FAILURE:** Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or Inderal should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of Inderal therapy. Therefore, when discontinuance of Inderal is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema) — PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. Inderal should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Inderal (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T₄ and reverse T₃, and decreasing T₃.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. Inderal (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that Inderal may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if Inderal (propranolol HCl) is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbital, and rifampin accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and lidocaine have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T₃ concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. Inderal has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. Inderal should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: Inderal is excreted in human milk. Caution should be exercised when Inderal is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasisiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. Inderal LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from Inderal Tablets to Inderal LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. Inderal LA should not be considered a simple mg-for-mg substitute for Inderal. Inderal LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION — Dosage must be individualized. The usual initial dosage is 80 mg Inderal LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS — Dosage must be individualized. Starting with 80 mg Inderal LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE — Dosage must be individualized. The initial oral dose is 80 mg Inderal LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, Inderal LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS — 80-160 mg Inderal LA once daily.

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Reference:

1. Data on file, Ayerst Laboratories.

D7295/188

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The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization for further information.

This list is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, The Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the UMDNJ. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

CARDIOLOGY

- April**
- 7 Cardiology Grand Rounds**
12 noon—Robert Wood Johnson Medical School, Academic Health Science Center, New Brunswick (UMDNJ)
 - 12 Clinical Arrhythmias**
12 noon-1 P.M.—Hospital Center at Orange (AMNJ)
 - 25 Advanced Cardiac Life Support Provider Course**
New Jersey Medical School, MSB, B-648, Newark (UMDNJ)
- May**
- 9 Cardiac Rehabilitation**
7-8 P.M.—Wallkill Valley General Hospital, Sussex (AMNJ)
 - 26 Anti-Arrhythmic Therapy**
3-4 P.M.—Ancora Psychiatric Hospital, Hammonton (AMNJ)
 - 26 Pathophysiology and Management of Acute Heart Failure**
11 A.M.—St. Joseph's Hospital and Medical Center, Paterson (St. Joseph's Hospital and Medical Center)

DERMATOLOGY

- April**
- 12 Dermatology Lecture**
8-10 P.M.—Schering Corporation—Kenilworth (The Dermatology Society of New Jersey)
 - 20 Dermatology Conferences**
6-9 P.M.—Rutgers Community Health Plan, New Brunswick (UMDNJ)
- May**
- 10 Annual Dinner, Dermatological Society of New Jersey**
6:30 P.M.—Chanticleer, Short Hills (Dermatological Society of NJ)
 - 18 Dermatology Conferences**
6-9 P.M.—Rutgers Community Health Plan, 57 U.S. Highway 1, New Brunswick (UMDNJ)

MEDICINE

- April**
- 2 Endocrine Series**
11:30 A.M.-1 P.M.—VA Medical Center, East Orange (AMNJ)
 - 4 Rheumatology Staff Conference**
5:30-7 P.M.—Robert Wood Johnson Medical School, MEB-393, New Brunswick (UMDNJ)
 - 6 The Otto Brandman M.D. Award Ceremony**
6-11 P.M.—The Hyatt Regency, New Brunswick (American Diabetes Association)
 - 6 Approach to the Patient with Joint Pain**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth (Alexian Brothers Hospital)
 - 7 Toxin Exposure and Risk Assessment**
4-6 P.M.—Coriell Institute, Camden (Cortell Institute)
 - 7 Functional Assessment of the Elderly**
2-3 P.M.—John E. Runnells Hospital of Union County, Berkeley Heights (AMNJ)
 - 11 Invasive Hemodynamic Monitoring**
7-8 P.M.—Wallkill Valley General Hospital, Sussex (AMNJ)
 - 13 Medical Grand Rounds**
10 A.M.—St. Mary Hospital, Hoboken (St. Mary Hospital)
 - 13 Septic Shock**
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic (AMNJ)
 - 13 Nephrotoxicity of Common Drugs**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove (AMNJ)
 - 13 Dilemmas in Osteoporosis**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth (Alexian Brothers Hospital)
 - 14 Human Population Monitoring**
4-6 P.M.—Coriell Institute,

- 28 Camden (Cortell Institute)
 - 19 AIDS, the Kidney, and Dialysis**
4-5 P.M.—Robert Wood Johnson Medical School, MEB, New Brunswick (UMDNJ)
 - 20 Nutritional Support**
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic (AMNJ)
 - 20 Indications and Counterindications to Lithotripsy**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth (Alexian Brothers Hospital)
 - 21 Cytogenetic Monitoring of Exposed Populations**
4-6 P.M.—Coriell Institute, Camden (Cortell Institute)
 - 21 Clinical Importance of New GI Hormones**
5-6 P.M.—Fuld Auditorium, Somerset Medical Center, Somerville (Somerset Medical Center)
 - 27 Transplants**
10:30-11:30 A.M.—Christ Hospital, Jersey City (Christ Hospital)
 - 28 MSNJ Annual Meeting**
9 A.M.—Sheraton Meadowlands Hotel, East Rutherford (MSNJ)
 - 28 Nutritional Assessment**
3-4 P.M.—Ancora Psychiatric Hospital, Hammonton (AMNJ)
 - 28 Visiting Professor Program**
1:30-2:30 P.M.—Saint Barnabas Medical Center, Livingston (Saint Barnabas Medical Center)
- May**
- 2 Rheumatology Staff Conference**
5:30-7 P.M.—Robert Wood Johnson Medical School, MEB-393, New Brunswick (UMDNJ)
 - 4 Computers in Medicine**
10:30-11:30 A.M.—Christ Hospital, Jersey City (AMNJ)
 - 4 New Approaches to Gastrointestinal Bleeding**
8:30-10:30 A.M.—Alexian Brothers Hospital, Elizabeth (Alexian Brothers Hospital)
 - 7 Endocrine Series**
11:30 A.M.-1 P.M.—VA Medical Center, East Orange (AMNJ)
 - 10 Chronic Pain Management and Issues Related to Iatrogenic Addiction**
12 noon-1 P.M.—Hospital Center at Orange (AMNJ)
 - 11 Medical Grand Rounds**
10 A.M.—St. Mary Hospital, Hoboken (St. Mary Hospital)
 - 11 New Treatments in Cerebrovascular Disease**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove (AMNJ)

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CARDIOLOGY UPDATE ...

designed for the Physician and provides an intensive survey of the
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WEDNESDAY
APRIL 6, 1988
3:00 to 5:00 PM

DIAGNOSIS AND MANAGEMENT OF
CONGESTIVE HEART FAILURE

MODERATOR: BERNARD L. SEGAL, M.D.

3:00-3:20	Clinical and laboratory diagnosis of heart failure	<i>Gary Vigilante, M.D.</i>
3:20-3:40	Drug therapy: old and new	<i>Mariell Jessup, M.D.</i>
3:40-4:00	Cardiac transplantation	<i>Grant V.S. Parr, M.D.</i>
4:00-4:30	Case presentations	<i>Michael Herlich, M.D.</i>
4:30-5:00	Panel discussion	<i>Peter G. Lavine, M.D.; Herbert E. Cohen, M.D.</i>

- No Registration Fee
- No Advance Registration Required
- CME Credits*

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- 11 Role of Operative Cholangiography in Biliary Tract Surgery**
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic (AMNJ)
- 11 Drug-Induced Lung Disease**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth (Alexian Brothers Hospital)
- 11 Annual Morris Saffron Lecture**
10 A.M.-2 P.M.—Medical Society of New Jersey, Lawrenceville (Medical History Society of New Jersey)
- 17 The Treatment of Glomerulonephritis**
4-5 P.M.—Robert Wood Johnson Medical School, MEB, New Brunswick (UMDNJ)
- 19 Fluid and Electrolyte Imbalance**
1:30-2:30 P.M.—Vineland Developmental Center and Hospital (AMNJ)
- 19 Clinical Issues in Human Sexuality**
5-6:30 P.M.—Somerset Medical Center, Fuld Auditorium, Somerville (Somerset Medical Center)
- 26 Visiting Professor Program**
1:30-2:30 P.M.—Saint Barnabas Medical Center, Livingston (Saint Barnabas Medical Center)
- 30 Caring for the Patient on a Ventilator**
1:30-2 P.M.—Health Maintenance Organization, New Brunswick (Rutgers Community Health Plan)

NEUROLOGY

May

- 11 New Treatments in Cerebrovascular Disease**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove (AMNJ)

OBSTETRICS/GYNECOLOGY

April

- 14 Joint Meetings**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston (Radiological Society of NJ, NJ Institute of Ultrasound, AMNJ)
- 28 Perinatal Conference**
7-9 P.M.—Newcomb Medical Center, Vineland (Newcomb Medical Center)

May

- 4 Cancer of the Cervix**
10:30-11:30 P.M.—Saint Mary's Hospital, Passaic (AMNJ)
- 18 Laparoscopy and Colposcopy**
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic (AMNJ)
- 20- Birth Injuries and the Law**
22 Resorts International Hotel, Atlantic City (UMDNJ)
- 25 Vaginal Discharge and P.I.D.**
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic (AMNJ)

- 26 Perinatal Conference**
7-9 P.M.—Newcomb Medical Center, Vineland (Newcomb Medical Center)

ONCOLOGY

April

- 4 Hematology/Oncology Conference**
12 noon-1 P.M.—Robert Wood Johnson Medical School, MEB-108A, New Brunswick (UMDNJ)
- 7 Tumor Board Conferences**
14 9-11 A.M.—Irvington
21 General Hospital
28 (Irvington General Hospital)
- 8 Cancer Research Colloquium**
15 12 noon-1:15 P.M.—New Jersey
22 Medical School, Newark
29 (UMDNJ)
- 13 Scientific Dinner Meeting**
27 6:30-9:30 P.M.—The Manor, West Orange (AMNJ)
- 28 Tumor Board Conferences**
12 noon—Newcomb Medical Center, Vineland (Newcomb Medical Center)
- 28 In Vivo Gene Mutations in Human T Lymphocytes**
4-6 P.M.—Coriell Institute, Camden (Coriell Institute)

May

- 2 Hematology/Oncology Conference**
12 noon-1 P.M.—Robert Wood Johnson Medical School, MEB-108A, New Brunswick (UMDNJ)
- 5 Tumor Board Conferences**
12 9-11 A.M.—Irvington General
19 Hospital
26 (Irvington General Hospital)
- 6 Cancer Research Colloquium**
13 12 noon-1:15 P.M.—New Jersey
20 Medical School, MSB, G-506B,
27 Newark (UMDNJ)
- 11 Scientific Dinner Meeting**
25 6:30-9:30 P.M.—The Manor, West Orange (AMNJ)

- 26 Tumor Board Conferences**
12 noon—Newcomb Medical Center, Vineland (Newcomb Medical Center)

ORTHOPEDICS

April

- 6 Sports Medicine**
10:30-11:30 A.M.—Christ Hospital, Jersey City (AMNJ)
- 7 Orthopaedic Grand Rounds**
14 7:30-9 A.M.—Robert Wood Johnson
21 Medical School, New Brunswick
28 (UMDNJ)
- 19- 1988 Annual Spring Meeting**
24 Aruba Palm Beach Hotel and Casino, Aruba (New Jersey Orthopaedic Society)

May

- 5 Orthopaedic Grand Rounds**
12 7:30-9 A.M.—Robert Wood Johnson
19 Medical School, New Brunswick
26 (UMDNJ)

PATHOLOGY

April

- 5 Renal Pathology Conference**
12 noon-1 P.M.—Robert Wood Johnson Medical School, New Brunswick (UMDNJ)
- 21 Hematopathology Conference**
4-5 P.M.—Robert Wood Johnson Medical School, New Brunswick (Muhlenberg Medical Center)

May

- 3 Renal Pathology Conference**
12 noon-1 P.M.—Robert Wood Johnson Medical School, New Brunswick (UMDNJ)
- 13- Eastern Regional Pathology**
14 Conference
Resorts International Hotel and Casino, Atlantic City (New Jersey Society of Pathologists)
- 19 Hematopathology Conference**
4-5 P.M.—St. Peter's Medical Center, New Brunswick (Muhlenberg Medical Center)

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June 11, 1988

8TH ANNUAL ADVANCES IN GASTROENTEROLOGY

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INFORMATION: Registration Supervisor, SLACK Incorporated, 6900 Grove Road, Thorofare, New Jersey 08086, 609-848-1000.

PEDIATRICS

April

- 5 Case Conferences**
- 12** 8-9 A.M.—Robert Wood Johnson Medical School, MEB-108A,
- 19** New Brunswick (UMDNJ)
- 7 Pediatric Grand Rounds**
- 14** 8:30-9:30 A.M.—Robert Wood Johnson Medical School, MEB-102,
- 21** New Brunswick (UMDNJ)
- 8 Advances in Pediatrics**
- 15** 9:30-10:30 A.M.—New Jersey Medical School, MSB, B-610,
- 22** Newark (UMDNJ)
- 29**
- 13 Craniofacial Abnormalities**
- 8 A.M.-4 P.M.—Children's Specialized Hospital, Mountainside (Children's Specialized Hospital)
- 15 Cardiac Arrhythmias in the Pediatric Age Group**
- 8 A.M.-12 noon—Overlook Hospital, Summit (Overlook Hospital)

May

- 3 Case Conferences**
- 10** 8-9 A.M.—Robert Wood Johnson Medical School, MEB-108A,
- 17** New Brunswick (UMDNJ)
- 24**
- 5 Pediatric Grand Rounds**
- 12** 8:30-9:30 A.M.—Robert Wood Johnson Medical School, MEB-102,
- 19** New Brunswick (UMDNJ)
- 26**
- 6 Advances in Pediatrics**
- 20** 9:30-10:30 A.M.—New Jersey Medical School, MSB, B-610, Newark (UMDNJ)
- 13 New Exanthems of Childhood**
- 8 A.M.-12 noon—Overlook Hospital, Summit (Overlook Hospital)

PSYCHIATRY

April

- 2 Case Seminars**
- 16** 8-10 P.M.—312 Harding Drive, South Orange (Advanced Psychiatric Study Group)
- 4 A Case of Cocaine Addiction**
- 8:15-10:15 P.M.—39 Crescent Avenue, Passaic (Essex Psychiatric Seminars)
- 16 Scientific Meeting**
- Saint Barnabas Medical Center (NJ Psychoanalytic Society)
- 20 Panic Disorder**
- 10:30-11:30 A.M.—Christ Hospital, Jersey City (Christ Hospital)
- 23 Medical and Psychiatric Aspects of Drug and Alcohol Abuse**
- 3-4 P.M.—Ancora Psychiatric Hospital, Hammonton (AMNJ)

May

- 2 Post-divorce Stress Disorder**

8:15 P.M.—326 Park Street, Montclair (Essex Psychiatric Seminars)

- 3 Developmental Disabilities**
- 10-11 A.M.—Green Brook Regional Center (AMNJ)
- 5 Case Seminars**
- 19** 8-10 P.M.—312 Harding Drive, South Orange (Advanced Psychiatric Study Group)
- 18 Treatment of Insomnia**
- 8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth (Alexian Brothers Hospital)
- 19 Scientific Meeting**
- Saint Barnabas Medical Center (NJ Psychoanalytic Society)
- 19 Clinical Issues in Human Sexuality—An Update on Drugs, Diseases, and Devices**
- 5-6:30 P.M.—Fuld Auditorium, Somerset Medical Center, Somerville (Somerville)
- 25 Depression in the Elderly**
- 8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth (Alexian Brothers Hospital)

RADIOLOGY

May

- 18 Dinner Meeting**
- 6:30-9:30 P.M.—The Manor, West Orange (Radiation Oncology Section-AMNJ)
- 19 Scientific Meeting**
- 7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston (AMNJ)

SURGERY AND SURGICAL SPECIALTIES

April

- 2 Surgical Treatment of Cardiothoracic Diseases**
- 10-11:30 A.M.—New Jersey Medical School, MSB, G-506, Newark (UMDNJ)
- 2 Morbidity and Mortality Conference**
- 16** 8:30-10 A.M.—New Jersey Medical School, MSB, B-610, Newark (UMDNJ)
- 23**
- 30**
- 4 Surgical Grand Rounds**
- 11** 4:30-5:30 P.M.—New Jersey Medical School, MSB, B-610, Newark (UMDNJ)
- 18**
- 25**
- 6 Surgical Procedures for Chronic Pancreatitis**
- 10:30-11:30 A.M.—Saint Mary's Hospital, Passaic (AMNJ)
- 11 Invasive Hemodynamic Monitoring**
- 7-8 P.M.—Wallkill Valley General Hospital, Sussex (AMNJ)
- 20 Surgical Conference**
- 11 A.M.—St. Mary Hospital, Hoboken (St. Mary Hospital)

- 26 In Vitro Fertilization Update**
- 8-10 P.M.—Englewood Club, 115 E. Palisade Avenue, Englewood (Englewood Surgical Society)

May

- 2 Surgical Grand Rounds**
- 9** 4:30-5:30 P.M.—New Jersey Medical School, MSB, B-610, Newark (UMDNJ)
- 16**
- 23**
- 7 Surgical Treatment of Cardiothoracic Diseases**
- 10-11:30 A.M.—New Jersey Medical School, MSB, G-506, Newark (UMDNJ)
- 7 Morbidity and Mortality Conference**
- 14**
- 21** 8:30-10 A.M.—New Jersey Medical School, MSB, B-610, Newark (UMDNJ)
- 28**
- 9 Management of Abdominal Emergencies**
- 10:30-11:30 A.M.—Saint Mary's Hospital, Passaic (AMNJ)
- 11 Role of Operative Cholangiography in Biliary Tract Surgery**
- 10:30-11:30 A.M.—Saint Mary's Hospital, Passaic (AMNJ)
- 18 Surgical Conference**
- 11 A.M.—St. Mary Hospital, Hoboken (St. Mary Hospital)
- 19-22 Annual Meeting, Eastern Vascular Society**
- The Willard Hotel, Washington, D.C. (Eastern Vascular Society)
- 24 AIDS Update**
- 8-10 P.M.—Englewood Club, 115 E. Palisade Avenue, Englewood (Englewood Surgical Society)

UROLOGY

April

- 1 Urology Grand Rounds**
- 9 A.M.—Robert Wood Johnson Medical School, MEB 108B, New Brunswick (UMDNJ)
- 27 Clinical Cases Presentation**
- 6:30-7 P.M.—Robert Wood Johnson Medical School, New Brunswick (UMDNJ)
- 27 Kidney Stones—Medical Approach**
- 8:30-10 A.M.—Alexian Brothers Hospital, Grassman Hall, Elizabeth (Alexian Brothers Hospital)

May

- 1 Urology Grand Rounds**
- Robert Wood Johnson Medical School, MEB-108B, New Brunswick (UMDNJ)
- 4 William P. Burbeau Award Dinner**
- 6:30-9:30 P.M.—The Manor, West Orange (Urology Society of New Jersey and AMNJ)
- 25 Clinical Cases Presentation**
- 6:30-7 P.M.—Robert Wood Johnson Medical School, New Brunswick (UMDNJ)

LETTERS TO THE EDITOR

Brand Medically Necessary; Ways To Avoid Malpractice

Brand Medically Necessary

November 16, 1987

Dear Doctor Krosnick:

The federal government has done it again. In the name of "cost containment" the Health Care Financing Administration (HCFA) has established new, restrictive prescribing and dispensing regulations for drugs prescribed for Medicaid patients. The burden of "accommodating" to these new rules, so that

Medicaid patients can continue to receive the drugs they need, of course, has been placed on health care practitioners, physicians, dentists, and pharmacists.

Specifically, HCFA has placed upper payment limits on a long list of multi-source drugs. They want prescribers to prescribe generic drug products and pharmacists to dispense generic drug products for Medicaid patients. However, they have left one avenue for prescribers to insist that a brand name product, instead of a generic, be dispensed from this long list of maximum allowable cost drugs.

That avenue is as follows: The prescriber must write, in his or her own handwriting on the face of the prescription (no telephone) the specific words "brand medically necessary." If the prescriber uses any other words to prevent substitution, pharmacists will be faced with a dilemma; he cannot dispense a generic and he will not be paid for the more expensive brand products by the government under the Medicaid program.

There are approximately 60 drugs affected by this new regulation, which is too long a list to memorize, and HCFA will be expanding this list as time goes on. To assure that Medicaid patients can obtain their prescribed drugs promptly, and to prevent a multitude of phone calls to prescribers by pharmacists, prescribers should begin writing "brand medically necessary" (pre-printing or rubber stamps are not allowed) on any prescriptions written for Medicaid patients if the

prescriber wants to prevent generic interchange on that prescription.

Respectfully,

Leon R. Langley

NJ Pharmaceutical Association

Ways To Avoid Malpractice

December 31, 1987

Dear Doctor Krosnick:

The cover story of the *NEW JERSEY MEDICINE* in the December 1987 issue is very laudable. However, I would like to add one more way to avoid malpractice suits: Many times a patient sees another doctor for a subtle complaint which may or may not be related to the previous treatment, such as surgery. All of a sudden, for some reason or another, the doctor tells the patient, "Had you seen me the first time, I would have done it differently." In other words, criticizing the work of another doctor without investigating in depth, invites malpractice suits.

(signed) Roy C. Cabrera, M.D.

January 22, 1988

Dear Doctor Krosnick:

I certainly agree with Dr. Cabrera. In reviewing malpractice cases, we continue to be impressed with the large number that are caused by the comment, or even the "raised eyebrow" of a second physician. Our article was dealing particularly with avoiding malpractice suits against oneself, and that is the reason this was not included. I appreciate the opportunity to call attention to this most important factor.

(signed) Paul J. Hirsch, M.D.

***The Age of Miracles;
Cranial Computed
Tomography and MRI;
Breast Imaging;
Snoring and Obstructive
Sleep Apnea***

***The Age of Miracles.
Medicine and Surgery in
the 19th Century***

Guy Williams. Chicago, IL, Academy. (\$16.95)

Although not a physician, Guy Williams grew up in a medical environment, with a father and a brother who were country practitioners. During the past 30 years, his writings on various aspects of social history always have indicated a more than casual interest in the development of our profession. Williams's latest book, *The Age of Agony*, devoted to an overly gruesome account of medical experience during the 18th century, apparently was intended as a prelude to the present work.

Here, the tone is quite rightly ebulliently optimistic. Beginning with the anatomical advances made by John Hunter and his followers, Williams proceeds to give us glowing accounts of such developments as the discovery of anesthesia, antiseptics, x-rays, and radium. Other chapters are devoted to midwives and obstetrics, mental healing and the asylum, and alternative medicine, including homeopathy, water cures, and herbal therapy.

I found the author's use of his material to be basically correct and informative, even though the style of writing is somewhat pedestrian and unstimulating. Written for the consumption of the general reader, the book also should prove useful to the medical historian as a review of the century which undoubtedly produced the most momentous advances in the entire history of medicine.

Morris H. Saffron, M.D.

***Cranial Computed
Tomography and MRI,
2nd Edition***

Seungho Howard Lee, M.D., and Krishna C. V. G. Rau, (eds). McGraw-Hill, 1987. Pp. 880. (\$125)

This new edition of a recognizedly excellent text adds the study of magnetic resonance imaging (MRI) to the basic format of its earlier volume.

After an initial review of the physics of computer tomography (CT) and MRI, the editors provide a review of anatomy utilizing gross sections, CT, and MRI. Their chapter on the orbit is extensive and with good quality CT scans; unfortunately, MRI is lacking here. Brain diseases are divided into chapters that include craniocerebral anomalies, trauma, tumors, and atrophy. The sections on the sella and temporal bone as well as the section on stroke are well written. The quality of the CT scans overall are of fair quality with some variance. MRI, for the most part, is relegated to a special section.

As with the first edition, the book's strong feature is that it is a very well written and extensive text. However, MRI does not receive the expanded treatment I had hoped to find here. Overall, for an excellent cranial CT text, this is the book.

Neil B. Horner, M.D.

***A Multimodality
Approach to
Breast Imaging***

Soar Porrath, M.D., (ed). Rockville, MD, Aspen Publishers, 1986. Pp. 384. (\$63.50)

This book aims to provide the "imager" with a perspective of his or her role in the diagnosis of breast diseases. In pursuit of that goal, Dr. Porrath had divided his work into comprehensively titled sections that

include imaging modalities, plastic surgery and psychology, benign diseases, malignant diseases, male breast diseases, and the post-irradiated breast.

The discussion of the chapters proceeds on similar lines. After a brief review of the topic, several case studies provide examples. The chapters tend to be short, but they are well written. Good quality pictures illustrate the chapters. However, technical aspects are not discussed in detail, and the subjects of diaphanography (transillumination) and thermography—a separate chapter on each concern—are of uncertain value. Although the book addresses itself to essential topics, it may be more useful to the physician who seeks a general and lucid introduction to the diagnostic modalities of breast diseases.

Neil B. Horner, M.D.

***Snoring and Obstructive
Sleep Apnea***

D.N.F. Fairbanks, S. Fujita, T. Ikamatsu, F.B. Simmons. New York, NY, Raven Press, 1987. Pp. 268.

This book was written by four authors and 12 contributors with the stated purpose to serve as a guide to sleep disorders for the otolaryngologist and the head and neck surgeon. This is reflected by the 21 pages devoted to medical therapy of the obstructive sleep apnea syndrome (OSA) as compared to the 90 pages regarding the surgical approach, in particular the procedure of uvulopalatopharyngoplasty—created by one of the authors and introduced into this country by another physician.

This is an indepth discussion of a subject not readily available, with a extensive discussion of snoring as presented in five segments.

The rambling, slightly repetitive and manipulative style aside, the book is a very readable and informative introduction to sleep-disordered breathing events. The chapters relating the cardiopulmonary pathophysiology of snoring and sleep apnea as well as nonsurgical therapeutics are excellent summaries of the recent literature.

This book fulfills its stated purpose for a reasonable price and can be recommended as an introductory text to all physicians.

Monroe S. Karetzky, M.D.

**Drs. Armstrong; Barata;
Bundens; Caruso; Douglass;
Earp; Eckstein; Feuer;
Goldman; Greenbaum;
Greenfield; McCune;
Meinhard, O'Neill, Small;
Vail; Vanderbeck**

Dr. Lorrimer Armstrong

After 47 years as a staff surgeon at Rahway Hospital, Lorrimer Armstrong, M.D., died on October 23, 1987, at the age of 87. He had been retired in Carmel, California, since 1977. Born in Shawnee, Oklahoma, Dr. Armstrong received his medical degree at the University of Pennsylvania School of Medicine, Philadelphia, in 1926. As a staff surgeon at Rahway Hospital, he was a member of the hospital's Board of Governors, president of the medical staff, and chief of surgery. In 1973, Dr. Armstrong was a recipient of the Rahway Hospital's prestigious Humanitarian Award. A member of our Union County component, he served on its Board for 40 years, including a presidential term. His active years of service to the Medical Society of New Jersey earned him the Society's Meritorious Service Award. Dr. Armstrong was a Fellow of the American and International Colleges of Surgeons, and was a member of the Academy of Medicine of New Jersey, of the American Medical Association, as well as an elected member of the Society of Surgeons of New Jersey. He was a recipient of MSNJ's Golden Merit Award in 1976.

Dr. Rogelio J. Barata

A specialist in general and thoracic surgery, Rogelio Jose Barata, M.D., died on September 26, 1987, at the age of 75. A native of Havana, Cuba, Dr. Barata received his medical degree from the Faculty of Medicine, University of Havana, Cuba, in 1940, maintaining a private surgical practice until 1961, when he emigrated to the United States. He became affiliated with St. Mary Hospital, Hoboken. A member of our Hudson County component, and of the American Medical Association, Dr. Barata was a Diplomate in both general surgery and thoracic surgery.

Dr. W. D. Bundens, Jr.

Warner Davenport Bundens, Jr., M.D., of Woodbury, died on September 9, 1987, at the age of 71. A native of Jefferson, Dr. Bundens received his medical degree from Temple University School of Medicine, Philadelphia, in 1941. As an orthopedic specialist, Dr. Bundens served in the United States Navy, from 1942 to 1964, emerging with the rank of captain. After retiring from the Navy, he became affiliated with Shriners Hospital, the United States Naval Hospital, Philadelphia General Hospital, all in Philadelphia, and Underwood Memorial Hospital, Woodbury. Dr. Bundens also was a professor of orthopedic surgery at Temple University School of Medicine. He was a Fellow of the American College of Surgeons, and of the American Academy of Orthopedic Surgeons, and was a member of the New Jersey Orthopedic Society, of our Gloucester County component, and of the American Medical Association.

Dr. Paul F. Caruso

Retired since 1985 in Dover, Delaware, Paul Felix Caruso, M.D., 78, died on November 27, 1987, after having served for 50 years as a general practitioner at Hackensack Medical Center. A native of Brooklyn, New York, Dr. Caruso was graduated from the University of Washington School of Medicine, Seattle, in 1935. During his 50-year tenure at Hackensack Medical Center, he served as a parasitology consultant and an associate attendant in pathology. Dr. Caruso was associate director of the arthritis clinic, co-founder of the tumor clinic, and was one of two

doctors to perform the first replacement transfusions in Bergen County. For these contributions and many years of service to the Medical Center, he received Hackensack Medical Center's Golden Award. He was a member of our Bergen County component and of the American Medical Association. Dr. Caruso served in the United States Navy during World War II, attaining the rank of captain. He received MSNJ's Golden Merit Award in 1985.

Dr. William C. Douglass

Retired in Lynchburg, Virginia, general practitioner William Courtney Douglass, M.D., died on October 1, 1987, at the age of 88. Born in Shanghai, China, Dr. Douglass received his medical degree from Cornell University Medical College, New York, in 1925. He maintained a partnership practice with his wife in Bernardsville for many years. A specialist in chest diseases, Dr. Douglass served as a tuberculosis clinician for Somerset county, and was a Fellow of the American College of Chest Physicians. He was a member of our Somerset County component and of the American Medical Association.

Dr. Ruth Earp

Retired Bernardsville general practitioner Ruth Earp, M.D., died at the age of 84 on November 20, 1987. A native of North Plainfield, Dr. Earp received her medical degree from Cornell University Medical College, New York, in 1928. She maintained a partnership practice with her husband in Bernardsville, and became a member of our Morris County component, of the American Medical Association, and of the American Association of General Practitioners. From 1929 to 1933, Dr. Earp was a medical missionary in Hunan, China. She was a 1978 recipient of the Medical Society of New Jersey's Golden Merit Award for her 50 years in medical practice.

Dr. David Eckstein

A retired specialist in internal medicine and geriatrics, David Eckstein, M.D., of Trenton, died on November 24, 1987, at the age of 75. Born in Trenton and a life-long area resident, Dr. Eckstein received his medical degree from Jefferson Medical College, Philadelphia, in 1938.

After 22 years of private geriatric practice in Trenton, Dr. Eckstein was a senior physician from 1968 to 1970 at Meadow Lakes Retirement Community, where he became medical director in 1970, continuing in that capacity until his retirement in 1981. He was a staff member of St. Francis Medical Center, Trenton, and The Medical Center at Princeton. Dr. Eckstein, as a member of the Medical Society of New Jersey, served as chairman of its Board of Trustees, and as chairman of its Committee on Biomedical Ethics. He served with the New Jersey Department of Community Affairs, receiving the Governor's Award from Governor Thomas H. Kean on November 12, 1987. Dr. Eckstein was past-president and co-founder of the New Jersey Medical Directors Association, and a former member of the American Medical Association's Committee on Aging, acting as an AMA delegate to the White House Conference on Aging in 1971. Former chairman of the Section on Long-Term Care of the American Geriatrics Society, Dr. Eckstein was a visiting lecturer with the Geriatrics Division of Family Practice, for the University of Medicine and Dentistry of New Jersey. Professional advisor of Governmental Health Programs (Medicare) Office, Prudential Insurance Company, he was a consultant with the Disability Review Section of the New Jersey Division of Pensions. Dr. Eckstein was a trustee of the Presbyterian Homes Foundation of New Jersey, and was medical director of the Adult Day Care Center at Mercer Street Friends. He was a member of our Mercer County component, of the American Medical Association, of the New Jersey Society of Clinical Pathologists, of the New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care, and of the New Jersey Nursing Home Administrators Licensing Board.

Dr. Joseph A. Feuer

After maintaining an internal medicine practice in Kearny for 50 years, Joseph A. Feuer, M.D., died on November 1, 1987, at the age of 78. Born in New York City, Dr. Feuer was graduated from the Long Island College of Medicine, Brooklyn, where he received his medical degree in 1933. He became affiliated with Newark Beth Israel Medical Center, and West

Hudson Hospital, Kearny, where he became president of the medical staff. A member of our Essex County component, of the American Medical Association, and of the Academy of Medicine of Northern New Jersey, Dr. Feuer was a Fellow of the American College of Chest Physicians and of the American College of Gastroenterology. He received MSNJ's Golden Merit Award in 1983 for 50 years of medical practice.

Dr. Solomon Goldman

Dermatologist Solomon Goldman, M.D., died on August 17, 1987, at the age of 86. A native of Austria, Dr. Goldman received his medical degree from Creighton University School of Medicine, Nebraska, in 1931. He became affiliated with Roosevelt Hospital, Metuchen, and St. Peter's Medical Center, and Robert Wood Johnson University Hospital (formerly Middlesex General Hospital), both in New Brunswick. A Diplomate in dermatology and a Fellow of the American Academy of Dermatology, Dr. Goldman was a member of our Middlesex County component, and of the American Medical Association. In 1981, he received MSNJ's Golden Merit Award for 50 years of medical practice.

Dr. Joseph Greenbaum

Joseph Greenbaum, M.D., an allergist, died on November 3, 1987, at the age of 79. A resident of Tenafly, he maintained a private practice in Teaneck for 36 years. Dr. Greenbaum also was a founding member of the Brooklyn Medical Group branch of HIP, where he practiced for 52 years, until the time of his death. A native of Brooklyn, New York, he received his medical degree from Long Island College of Medicine, New York, in 1934. During World War II, he served as a Captain in the United States Army medical corps. He was a member of our Bergen County component, and a Fellow of the American Academy of Allergy, of the American College of Allergy, and of the New Jersey Allergy Society. For his 50 years of medical practice, Dr. Greenbaum received MSNJ's Golden Merit Award in 1984.

Dr. William J. Greenfield

Retired in North Palm Beach, Florida, after years of practice in

rhinology and plastic surgery, William John Greenfield, M.D., died on September 29, 1987, at the age of 98. Born in Clara City, Minnesota, Dr. Greenfield received his medical degree in 1918 from the University of Michigan Medical School, Ann Arbor. He became affiliated with Hackensack Medical Center. A Diplomate in otolaryngology, Dr. Greenfield was a Fellow of the American College of Surgeons, and of the American Academy of Ophthalmology and Otolaryngology, and was a member of our Bergen County component, and of the American Medical Association. He was a 1968 recipient of MSNJ's Golden Merit Award.

Dr. Carrol R. McCune

Carrol Richard McCune, M.D., 64, died on December 7, 1987, after 35 years as a family practitioner in Pompton Plains. Born in East Rutherford, Dr. McCune received his medical degree from Georgetown University School of Medicine, Washington, D.C., in 1951. A resident of Pompton Plains for 35 years, Dr. McCune was a physician for the Pompton Plains schools. He became affiliated with Chilton Memorial Hospital, Pompton Plains, and was a member of our Passaic County component, and of the American Medical Association. During World War II, he served as a United States Navy navigator.

Dr. Fred Meinhard

Family practitioner Fred Meinhard, M.D., died on September 20, 1987, at the age of 72. A native of Newark, Dr. Meinhard received his medical degree from Creighton University School of Medicine, Nebraska, in 1937. A specialist in allergy, Dr. Meinhard was affiliated with Clara Maass Medical Center, Belleville, and St. James Hospital, Newark. He was a Diplomate in family practice, a Fellow of both the American Academy of Allergy and of the American College of Allergy, and was a member of our Essex County component, of the New Jersey Academy of Allergy, and of the American Medical Association. During World War II, Dr. Meinhard served in the United States Army, emerging with the rank of lieutenant colonel. He was a Golden Merit Award recipient in 1987.

Dr. Joseph F. O'Neill

Retired since 1979 in Whiting, family practitioner Joseph Francis O'Neill, M.D., died on November 19, 1987, at the age of 77. Born in Trenton, Dr. O'Neill was graduated from Hahnemann Medical College, Philadelphia, in 1935. He resided in Hopewell, maintaining a family practice until his retirement in 1978. Dr. O'Neill was a member of our Mercer County component and of the American Medical Association. For his 50 years as a physician, Dr. O'Neill received MSNJ's Golden Merit Award in 1985.

Dr. Louis Small

Retired one year after over 45 years of family practice in Passaic, Louis Small, M.D., died on November 25, 1987, at the age of 84. Born in Passaic, and a life-long area resident, Dr. Small received his medical degree from Jefferson Medical Col-

lege of Philadelphia, in 1936. In addition to his private practice, he became affiliated with the General Hospital Center at Passaic, as well as Beth Israel Hospital, Passaic. He was a United States Army medical corps veteran of World War II, having attained the rank of captain. Dr. Small was a member of our Passaic County component and of the American Medical Association. In 1986, he received MSNJ's Golden Merit Award.

Dr. William D. Vail

Retired specialist in occupational medicine, William Davis Vail, M.D., died on February 15, 1987, at the age of 68. A native of New York City, Dr. Vail was graduated from Columbia University College of Physicians and Surgeons, in 1944. He became affiliated with Overlook Hospital, and St. Barnabas Medical Center. Dr. Vail was a member of our Essex County component and of the AMA.

Dr. James J. Vanderbeck

Retired obstetrician-gynecologist James Joseph Vanderbeck, M.D., died on November 29, 1987, at the age of 82, in Chicago. Born in Paterson, Dr. Vanderbeck received his medical degree from Georgetown University School of Medicine, Washington, D.C., in 1933. He maintained a private practice for 32 years in Ridgewood, and became affiliated with St. Joseph's Hospital and Medical Center, Paterson, and Valley Hospital, Ridgewood. He was a member of our Bergen County component, of the American Medical Association, and of the New Jersey Obstetrical and Gynecological Society. During World War II, Dr. Vanderbeck served with the United States Army medical corps, emerging with the rank of captain. In 1983, he received the Medical Society of New Jersey's Golden Merit Award for his 50 years as a physician in his community.

AUTHOR INFORMATION

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CONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable

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Submit two **manuscripts** that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods used in articles should be identified. Acknowledgements will be made only for specific preparation of an essential part of the manuscript.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

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Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the

source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The **summary** of the article should not exceed 250 words; it should contain only essential facts.

References should not exceed 35 citations except in review articles, and should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8½" by 11" sheets in the numerical order in which they are first cited in the text. The style of reference is that of *Index Medicus*:

1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

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Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Editorial Board. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors.

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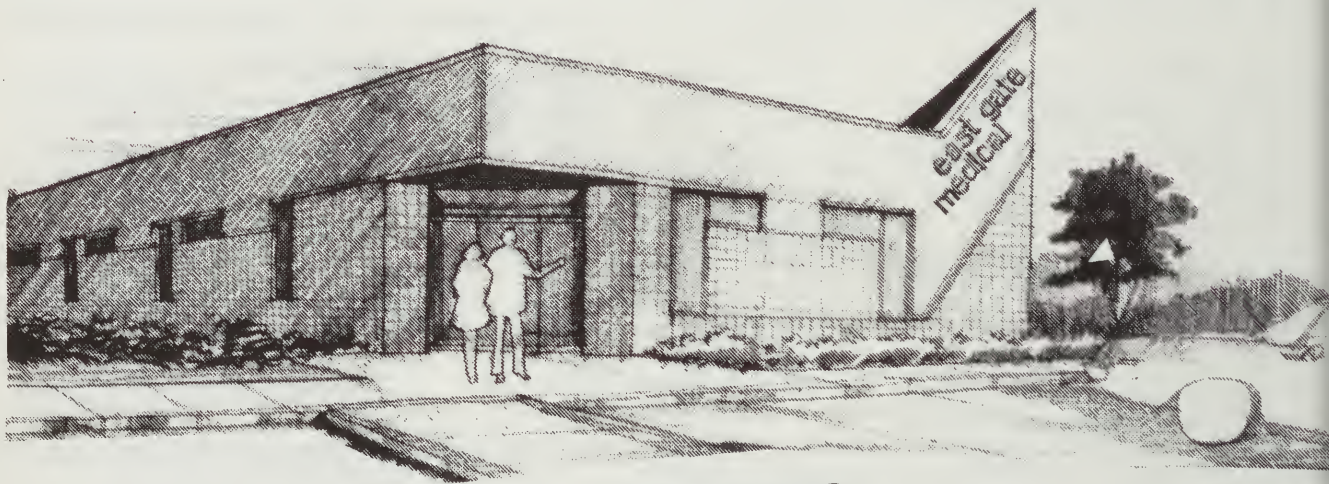


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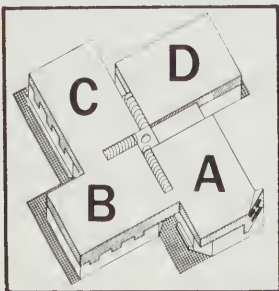


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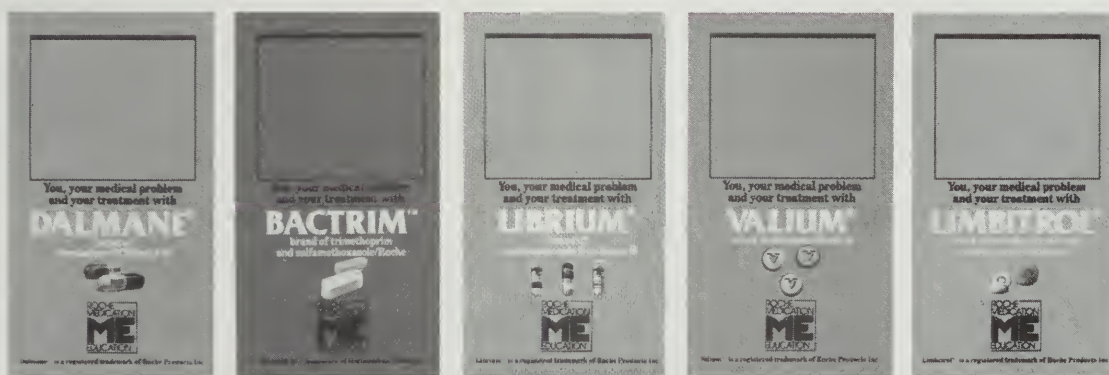


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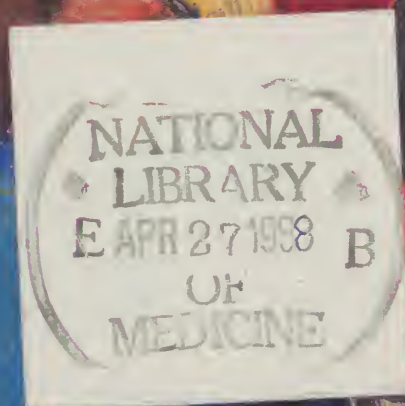
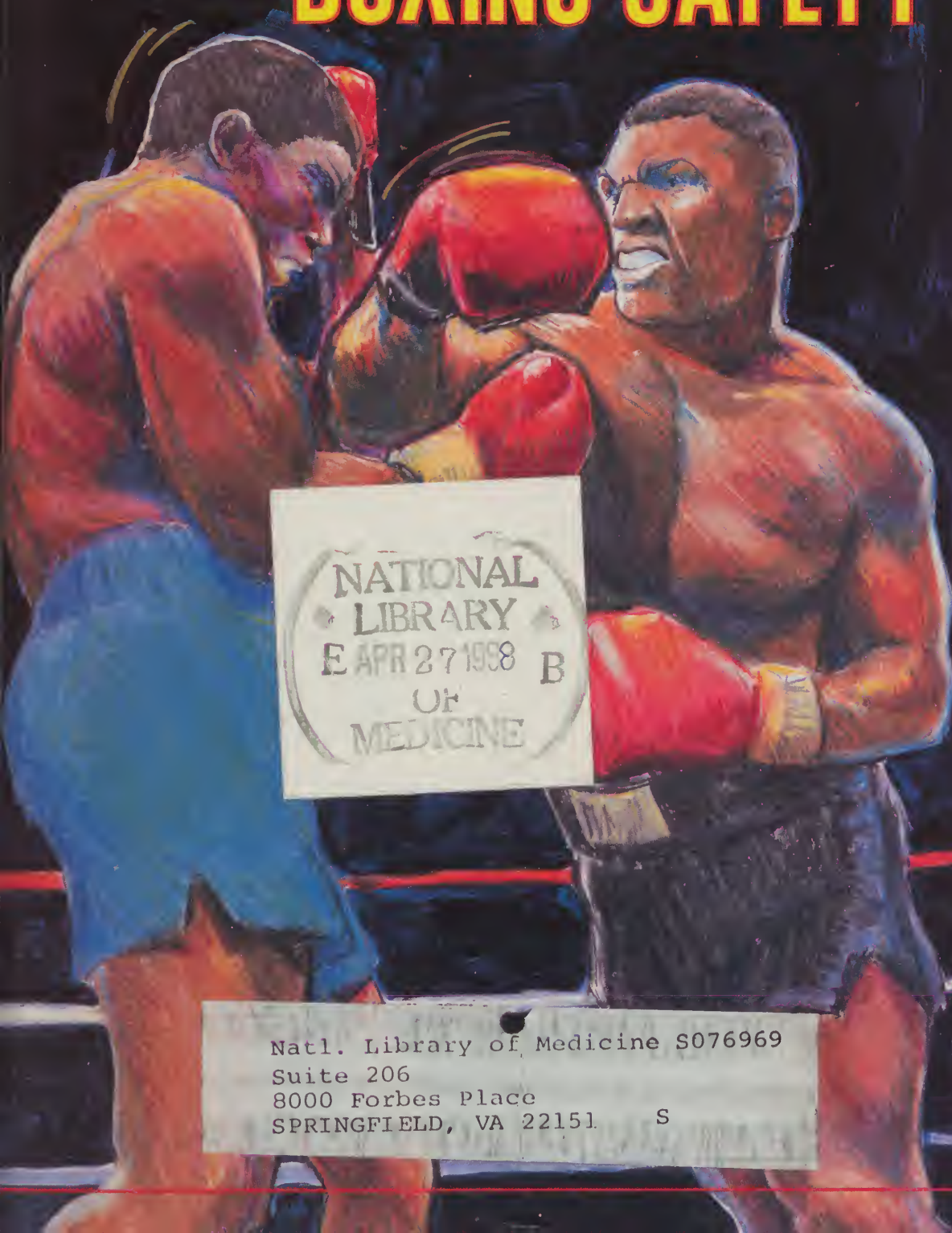
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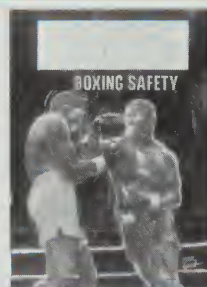
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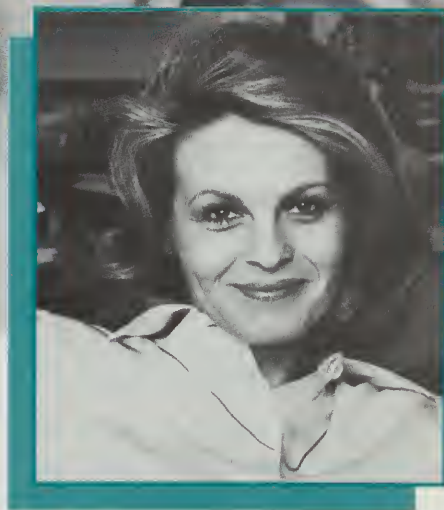
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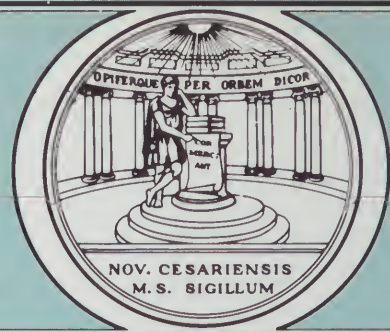
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MEMBERSHIP NEWSLETTER



THE MEDICAL SOCIETY OF NEW JERSEY

VOLUME 53

MEDICARE

Changes Affecting Patients and Physicians

Containing 118 provisions impacting on Medicare, Medicaid, and other health-related government programs, the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) was signed by President Reagan on December 22, 1987. Most provisions of the new law became effective April 1, 1988.

Maximum Allowable Actual Charges (MAACs), prevailing and customary charges, and laboratory fee schedules remain frozen at 1987 levels during the first three months of 1988. In addition, physicians will have a second sign-up period for the Medicare participation program. Participation agreements signed at this time became effective April 1, 1988.

New physicians, defined as those who start providing care to Medicare beneficiaries for the first time after April 1, 1988, will be reimbursed at 80 percent of the Medicare Economic Index (MEI) adjusted prevailing charge. New physicians providing primary care services and services furnished in designated rural areas will be reimbursed at the 50th percentile level, unadjusted prevailing charge (this will be higher).

Increases in the MEI. The Medicare Economic Index (MEI) increased as of April 1, 1988. Another update is scheduled January 1, 1989. Physician's customary and prevailing charges will be based on actual charges from July 1, 1986, to June 30, 1987. Participating physicians will receive a 3.6 percent update on primary care services and a 1 percent update on all other services as of April 1. Primary care services are defined as: office medical services; emergency department services; home medical services; skilled nursing, intermediate care, and long-term care medical services; or nursing home, boarding home, domiciliary, or custodial care medical services.

Nonparticipating physicians will receive 4.5 percent less than participating physicians.

There will be no increase on new physician services such as supplies and clinical lab.

Overpriced Procedures. Beginning April 1, 1988, Medicare reimbursement for a number of surgical procedures the Health Care Financing Administration (HCFA) labeled "overpriced" have been reduced from 2 to 15 percent. The amount of the reduction depends upon how much the area prevailing charge exceeds 85 percent of the national average prevailing charge.

The procedures involved include coronary artery bypass, total hip replacement, cataract surgery, transurethral prostatectomy, suprapubic prostatectomy, diagnostic and/or therapeutic dilatation and curettage, carpal tunnel neurolysis and/or transposition, pacemaker surgery, bronchoscopy, upper gastrointestinal endoscopy, knee arthroscopy, and knee arthroplasty.

Specialty Issues. From April 1, 1988, through December 31, 1990, physicians who concurrently direct two or more nurse anesthetists will have their reimbursement reduced. The reduction is 10 percent for two nurse anesthetists, 25 percent for three nurse anesthetists, and 40 percent for four nurse anesthetists. There also is a 10 percent reduction beginning January 1, 1989, for each concurrent iridectomy or cataract surgery nurse anesthetist supervision.

A radiologic fee schedule with limits on actual charges will be developed for 1989. This is restricted to board certified or board eligible radiologists. In-office laboratory services billed to Medicare must be taken on assignment. Penalties now apply to physicians who bill patients for these services.

Physicians who purchase diagnostic and other x-ray services cannot charge more than the actual costs as of April 1, 1988. As of January 1, 1988, all clinical laboratory services must be accepted on assignment. A physician may not bill the patient on a nonassigned basis or penalties can be applied for a single, deliberate violation.

Ambulatory Surgery Center Services. Medicare payment for physicians' services furnished after March 31, 1988, in an ambulatory surgical center (ASC) or a hospital outpatient department on an assigned basis will be subject to deductible and coinsurance requirements. All services will be paid at 80 percent of the prevailing charge even when assignment is accepted.

Physicians must collect the remaining 20 percent from the patient or supplemental insurance. An intraocular lens implanted in an ASC must be billed by the facility.

Peer Review Organizations. The budget bill contains a number of provisions related to the PRO program. PROs now are required to provide reasonable notice and opportunity for discussion prior to denial.

of a claim. Of particular interest to small and rural hospitals is a new requirement for "significant on-site review activities, including on-site review in at least 20 percent of the rural hospitals in the PRO's area."

Another significant provision of the law calls for "pre-exclusion hearings." Before the secretary of the U.S. Department of Health and Human Services (HHS) may exclude a physician or provider located in a rural area from the Medicare program, a hearing before an administrative law judge is required. In addition, the secretary is required to file a report to Congress on these "improvements" to the PRO program.

Considerations About Participation. There are a number of factors to consider when making your participation decision: the proportion of patients in the practice who are Medicare beneficiaries; current percentage of patients and dollars taken on assignment; 1987 experiences with MAACs or participating physician status; participating physicians are required to accept assignment in all cases—nonparticipating physicians have the option of accepting Medicare assignment on a case-by-case basis; Medicare's preferential treatment of participating physicians (for example, a financial disclosure letter is required of nonparticipating physicians performing nonemergency surgery where total charges exceed \$500); the difference between the 1988 prevailing charge and the 1988 MAACs; and the physician's individual philosophical stance on participation.

DEPARTMENT OF HUMAN SERVICES

Hearing Aid Assistance

A new program, "Hearing Aid Assistance to the Aged and Disabled (HAAAD)," became effective February 4, 1988. This program pays over \$100 towards the cost of a hearing aid to individuals who are over age 65 or receiving Social Security disability benefits and meet income and residency guidelines. Annual income must not exceed \$13,650 for a single individual or \$16,750 for a married couple. The person must have established a permanent legal residence in New Jersey for 30 days before applying. Applications may be obtained by calling 1-800-792-9745.

AMERICAN MEDICAL ASSOCIATION

Health Care Costs Rise

The cost of providing health care benefits to employees jumped to an average of \$1,985 per worker last year as employers hunted for new ways to control costs. A poll of 2,016 corporate and government employers found that their costs rose 7.9 percent last year, or an average \$128 per employee, said A. Foster Higgins & Co. which conducted the survey. The average cost had risen 7.7 percent in 1986.

MEDICAL SOCIETY OF NEW JERSEY

Carrier-Directed Medical Audits

A number of casualty carriers and certain health insurers have been using audit firms in their claims payment and settlement practices. These audit firms usually will request copies of patient records and also will attempt to negotiate with physicians for reduced fees.

Audit firms are entitled to review a patient's record when they present a signed patient release. When you

are advised that they are reducing your fees or questioning utilization, ask for a statement in writing. Also, please remember that medical necessity determinations are a physician function. Therefore, you should request the name of the physician being used by the audit firm.

Finally, it should be noted that some firms attempt to leverage a settlement by offering to pay 75 or 80 percent of the bill amount rather than "conducting an audit of the records." This "save your grief" technique is not approved by the Insurance Department and encourages manipulation. Please remember that claim adjusters and audit companies justify their existence by reductions in payment.

If you have any questions regarding the problems discussed, or other reimbursement issues, please call Joseph C. Lucci, Director, Medical and Insurance Affairs, MSNJ, 609/896-1766.

SOCIAL SECURITY ADMINISTRATION

AIDS Patients

Low-income people with AIDS are eligible to receive Supplemental Security Income and Medicaid benefits as soon as they are diagnosed with the disease, under regulations made final by the Social Security Administration. Publication of the new rule is not expected to change actual practices since interim regulations in effect since 1985 follow the same basic guidelines.

AMA ADVISORS

Investing Abroad

A decade ago, a diversified portfolio for an individual investor simply meant owning domestic stocks and bonds, with perhaps some gold or real estate thrown in. But today, more and more investors are realizing that there are as many investment opportunities beyond U.S. shores as within them. Foreign stocks, bonds, and money market assets are being discovered by individuals.

There are several reasons why venturing overseas with your investment dollars makes sense. First, investing abroad offers a wider scope of investment possibilities. Patriotism aside, the world's largest and fastest growing companies no longer are housed only in the United States.

Taking a global view also increases the diversification of your portfolio, thereby lowering your overall investment risk. The world's economies don't move in lockstep. So even if political uprisings are hurting investments in southeast Asia, it is unlikely they will affect investments in Europe. And if the U.S. stock market temporarily hits a sour note, you may find better pickings in Japan.

Investing abroad also introduces the two-edged sword of currency fluctuations. Suppose you buy British bonds at a time when \$1.75 buys one British pound. You invest \$17,500 to get bonds worth 10,000 pounds. Then the dollar weakens, and a pound equals \$1.90. If you sold your bonds for dollars, you would get \$19,000. That's a \$1,500 profit just on the currency exchange. Of course, if the dollar had strengthened to \$1.60 per pound, you would have lost \$1,500 on the transaction.

How to Buy Foreign Investments. The most direct way to buy foreign stocks or bonds is on the foreign

exchange where the asset is traded. Of course, for individual investors that is easier said than done. The larger brokerage houses often have offices abroad that could execute the trade for you, but your individual broker may be unfamiliar with the procedure. And don't forget to figure in the cost of such a trade.

Some foreign stocks are traded here in the U.S. For instance, shares of two Dutch companies, Royal Dutch Petroleum and KLM Royal Dutch Airlines, both trade on the New York Stock Exchange. Other foreign stocks trade in the U.S. as American Depositary Receipts, commonly called ADRs. An ADR is not an actual stock certificate. Banks holding the stock in vaults overseas issue the ADRs as claims on those shares. ADRs of Sweden's Volvo AB and Britain's Cadbury Schweppes are both available in the U.S. over-the-counter. Japan's Honda Motor ADRs trade on the New York Stock Exchange.

Of course, if you buy your foreign stocks and bonds directly or through ADRs, you will have to be your own investment adviser, which is no mean feat. Investing outside of the U.S. is as fraught with perils as it is with opportunities. There's the task of researching companies located on the other side of the globe. Unless you go to a specialty brokerage firm, your broker may have little or no advice to give you.

You'll also have to keep tabs on the economic situation in numerous countries. You will need to know if any government's policies are about to change. Then there is the political scene. South Africa is a great place to look for gold stocks, but is civil unrest going to undermine your investment? Even if you sidestep all countries going through political or economic upheavals, you can't avoid playing the currency game.

That is why we think the best advice for investors looking overseas is to find a good mutual fund. With mutual funds, professional managers keep track of each market's gyrations and do the stock and bond selecting for you. You get diversification with minimum investments of only a few thousand dollars or less. And you will probably save on commissions and trading costs, particularly if you buy a "no-load" fund, that is, one with no sales commission.

You can select either an international fund or a global fund. International funds buy both domestic and foreign securities, so the manager has more flexibility to pick and choose investments. You also will be able to choose from among funds specializing in foreign stocks, foreign bonds, foreign money market investment, even funds specializing in securities for just one country, like Japan or Korea.

For your first venture abroad, it's probably best to select a fund that invests worldwide and one that gives the fund manager the most latitude. After all, you hired that manager to make foreign securities decisions for you. You should let the manager do just that.

MSNJ ANNUAL MEETING

The Inaugural Reception and Dinner Dance

The Middlesex County Medical Society and the Medical Society of New Jersey cordially invite you to join us in the celebration of the inauguration of Palma E. Formica, M.D., as the first woman President of the Medical Society of New Jersey at a gala Inaugural Reception and Dinner Dance on Saturday, April 30, 1988, in the Diamond Court Ballroom of the Sheraton Meadowlands Hotel, East Rutherford, New Jersey.

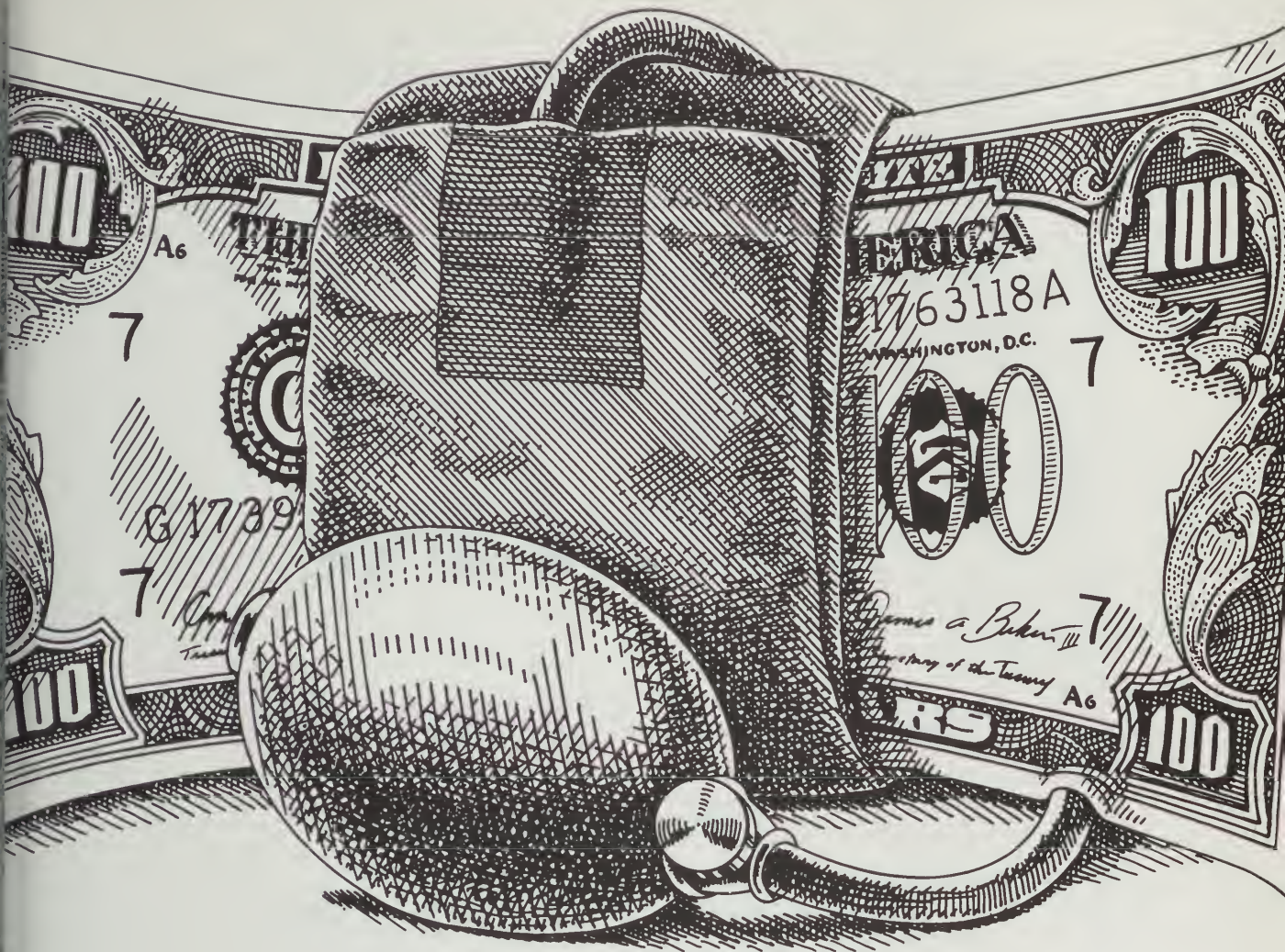
The Reception will be held at 6:00 P.M. in the Derby Ballroom. Tickets for this event will be \$5 per person and can be purchased in advance through the Middlesex County Medical Society or at MSNJ's Registration Area at the hotel.

The Inaugural Dinner Dance will be held at 7:30 P.M. in the Diamond Court Ballroom. Tickets for this will be \$50 per person and also may be purchased in advance from the Middlesex County Medical Society or at MSNJ's Registration Area at the hotel.

Please join Dr. Formica, the Middlesex County Medical Society, and the Medical Society of New Jersey for what promises to be a most enjoyable and fun-filled evening.

FINI

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GOVERNMENTAL AFFAIRS UPDATE: CLARK MARTIN, MSNJ LEGISLATIVE CONSULTANT

DETERING PHYSICIAN ASSISTANTS' ADVANCES

Agreeing with the Society and the State Nurses Association, the Assembly has passed a bill which affirms that only the Legislature has the power to create a health care license.

Although simple in substance, A-1591 is symbolically significant. Sponsored by Assemblyman John Bennett (R-Freehold), the bill was introduced to block the Health Department's attempt to promote the licensure of physician assistants by regulation. The bill makes it clear that no state agency may license or otherwise allow a category of health care profession to practice unless first authorized by the Legislature.

After passing in the lower house, A-1591 has advanced to the Senate Committee on Institutions, Health and Welfare. A similar measure, S-1491, also has been referred to that Committee.

Passage of A-1591, by 41 "yes" votes with 15 "no" and 24 abstentions, came after an extended debate. Working against the bill were the physician assistants, the Health Department, and UMDNJ. The controversy over the bill is reflected in its receiving only the minimum number of votes required for passage in the lower house.

Voting for the bill were: Bennett, Cimino, Colburn, Collins, Crecco, Deverin, Doyle, Farragher, Felice, Franks, Frelinghuysen, Genova, Girgenti, Hardwick, Haytaian, Hendrickson, Hudak, Impreveduto, Kamin, Kelly, Kern, Kline, Kyrillos, Littell, LoBiondo, Loveys, Martin, Moran, Naples, Palaia, Randall, Rocco, Roma, Rooney, Schuber, Shinn, Shusted, Singer, Smith (J.), Stuhltrager, and Villane.

Voting against the bill were: Adubato, Albohn, Bush, Duch, Gill, Kenny, Mattison, Menendez, Miller, Ogden, Pascrell, Roberts, Salmon, Schwartz, and Zecker.

Abstaining were: Baer, Brown, Bryant, Charles, Cooper, Doria, Foy, Kalik, Karcher, Kavanaugh, Kronick, Marsella, Mazur, McEnroe, Otlowski, Patero, Pelly, Penn, Riley, Schluter, Smith (R.), Spadoro, Watson, and Zangari.

SOCIETY TACKLES SURCHARGE PLAN

In what may become a protracted battle, the Medical Society of New Jersey has taken its first step to fight

Insurance Commissioner Ken Merin's plan to levy a 4 percent surcharge for the next seven years on every physician's professional liability insurance premium.

The surcharge plan, published as a "preproposal" in the *New Jersey Register* in early February, would be used to pay the debts of the state's now defunct Medical Malpractice Reinsurance Association. Its estimated \$60 million deficit was caused by the state's selling its malpractice insurance to physicians at unreasonably low premiums.

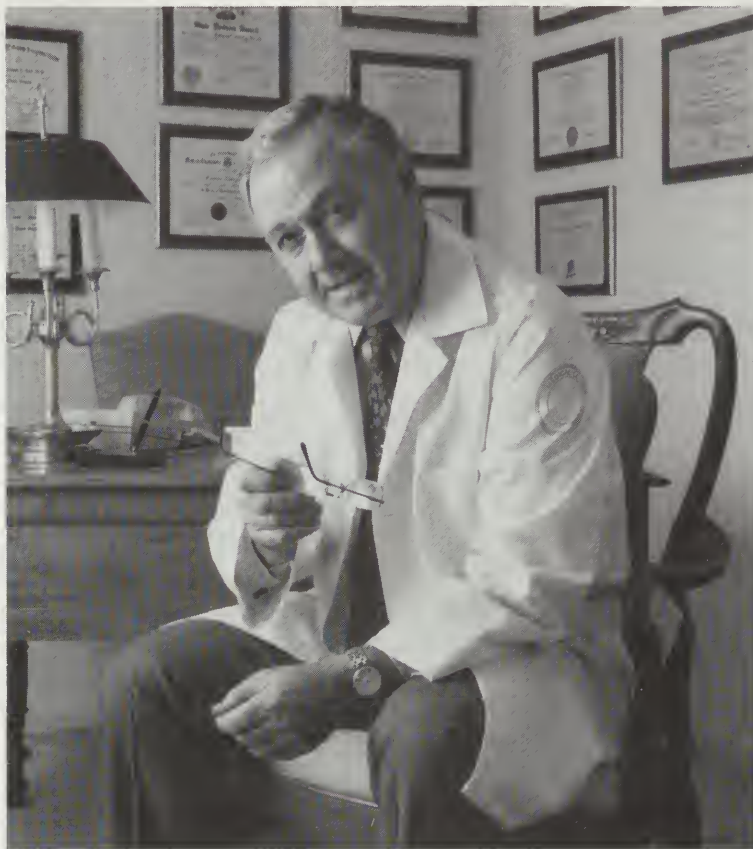
Surcharge proposals seem to be proliferating in the Insurance Department. In quick succession, Commissioner Merin has proposed the malpractice bail out as well as surcharges on auto insurance to prop up the assigned risk pool and on health insurance to subsidize Blue Cross.

The malpractice surcharge has yet to be proposed as a formal rule. But the Society has written Commissioner Merin to express its opposition and point out some of the obvious inequities of his plan. For example:

- The Medical Malpractice Reinsurance Association had insured hospitals during its five years of operation. Yet, hospitals would not be included in the surcharge.
- The proposal would require thousands of physicians who did not buy the state's "bargain" insurance to pay the surcharge, but it is silent about whether physicians employed by governmental agencies are to be included. Yet, some of these physicians purchased their coverage from the state.
- The surcharge plan is based on "guess-timates." No one knows how large the debt will grow; that depends on the outcome of pending lawsuits. And no one knows how much revenue would be raised by the surcharge; that depends on whether malpractice premiums stabilize or continue to rise while the surcharge is in effect.

In any event, the Society is prepared to fight the surcharge on all fronts: regulatory, legal, and legislative.

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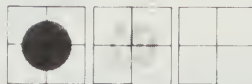
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The Physical Therapy Bill—Again

PAUL J. HIRSCH, M.D.*

The physical therapy bill is wrong for patients and for New Jersey. The author urges readers to write or call their Congressmen.

The notorious physical therapy bill, which New Jersey physicians fought to a standstill last year, has been reintroduced in both houses of the 1988-89 Legislature. The bill (A-2647/S-2129 last year, now reincarnated as A-587/S-2091) would prohibit physicians from employing physical therapists or having a financial interest in any facility which provides physical therapy services.

Nowhere has such legislation—which would prevent one class of citizens from employing another—been enacted into law.

We believe strongly that this bill would downgrade the quality of medical care in New Jersey and would interfere with the rights of our patients. This special-interest legislation benefits no one, except for the small group of physical therapists who own their own businesses. Ironically, while the bill would place unprecedented restrictions on the physician's practice, it would create financial incentives for physical therapists to employ physicians. The bill is anticonsumer in every respect. Last year, this legislation was opposed by the New Jersey Division of Consumer Affairs, as well as by the Federal Trade Commission (FTC).

Although the bill was introduced in both houses in the last session, most of us know of it by its Assembly number. This is because the battle was fought in the lower house. The Senate bill wasn't even discussed in Committee.

On May 21, 1987, the FTC issued an opinion on A-2647 stating this legislation would "restrict competition" and "is likely to injure consumers by reducing competition among physical therapy providers." The FTC further noted that "A-2647 also could limit a physician's ability to oversee the care provided to patients."

In a previous opinion, in October 1986, the FTC opposed proposed regulation in Nevada, which would have prohibited a physical therapist from being employed by a physician. The FTC stated: "Because of their adverse effects on consumer welfare, the Commission has taken legal action against restrictions on employment relationships in health care practice."

It is clear that A-587/S-2091 would interfere with the quality of medical care in New Jersey. And the bill obviously is bad news to hundreds of physical therapists who are employed by physicians, many of whom would lose their jobs under this legislation.

Last year, physicians in New Jersey made an intensive effort to oppose and defeat this legislation. We must do so again!

In summary:

- A-587/S-2091 is special interest legislation designed to protect the economic interests of those physical therapists who own their own practices.
- There is no evidence that this bill would benefit the public, or public health.
- A-587/S-2091 is anticonsumer in every respect. By eliminating competition, it negates the opportunity to reduce costs.
- A-587/S-2091 reduces opportunities for a physician and physical therapist to work closely together for the benefit of their patients.
- This proposed legislation would narrow the freedom of choice available to the consumer.
- This legislation would be regressive, failing to recognize the current trends in our health care delivery system which are leading to full services at one location.
- If passed, this bill could set a precedent in other areas.

This legislation is wrong for our patients and wrong for New Jersey, and must be defeated. I urge you to write or call your Assemblymen and Senators.

*Dr. Hirsch is First Vice-President of the Medical Society of New Jersey.



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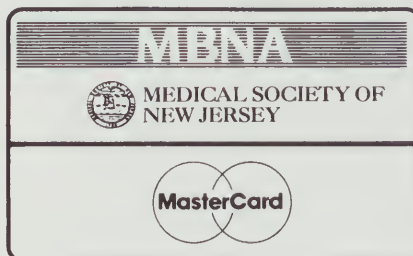
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Controlling Your Practice

Blueprint for Medical Office Claims Prevention Survey; Physician's Assistant Convicted of Criminal Charges; Virginia Ceiling Unconstitutional

A BLUEPRINT FOR A MEDICAL OFFICE CLAIMS PREVENTION SURVEY

Many malpractice claims which involve both treatment and nontreatment factors are traced to inadequate policies and procedures, communication gaps between caregivers and patients, and flawed communication among health professionals. The incident or issue which triggers a lawsuit may occur even before the physician sees the patient or before medical treatment is rendered. Consider these often-overlooked liability factors:

Scheduling. Are too many patients seen in too little time? Sufficient time must be set aside for each appointment, depending on the reasons for the visit. A flat policy of scheduling patients every x minutes, regardless of the purpose of the visit, invites inevitable delays. A complete physical obviously takes more time than a suture check. Patient opinion polls indicate that what patients dislike most about going to the physician is the long wait. Encourage your staff to ask patients the reason for their visit and establish a system for setting aside time slots according to the patients' problems. Receptionists should ask patients, "Please tell me what you would like to see the physician about so that I can be sure to schedule enough time."

If your patients habitually wait, do a patient flow survey to determine why. Many physicians set aside one to three appointment blocks each day to accommodate emergencies and unexpectedly extended visits. Staff can defuse patients' anger by informing them about delays when they arrive. Giving the patient an opportunity to reschedule or run an errand in the interim shows respect for the patient's time. Most im-

portantly, both staff and physician should apologize to patients if they are kept waiting. And consider changing the name from "waiting room" to "reception room."

Telephone Etiquette. Does your staff create a positive image of your practice on the telephone? The initial impression new patients form of your practice can be influenced by the manner in which staff handles telephone communications. Staff should follow these guidelines:

1. Answer calls promptly; identify the office practice name and give your name. ("Dr. Brown's office. This is Susan. May I help you?")

2. Before placing a caller on hold, say, "Just a moment, please," instead of going off the line without a word, leaving the caller to wonder if he or she was disconnected.

3. At the physician's direction, staff may ask, "May I tell the physician what the call is about?" instead of asking, "Is this personal?" "Are you a patient?" "Have you been here before?" When the person answering learns the nature of the call, the information should be passed on to the physician, so that he or she does not sound uninformed when the call is taken.

4. When callers wait on hold, the receptionist should come back on the line to let them know they have not been forgotten and apologize for any delays.

5. Callers should be addressed as Mr., Mrs., Miss, or Ms., but not by their first names, unless they are personally known to the staff. Many people (nearly 20 percent in a recent survey) resent being addressed informally by unidentified medical office personnel.

6. Stress or work-related problems should not influence staff's treatment of patients. Patients understandably believe their problems are more important than how hard staff members think they are working. An unpleasant, curt, hostile, or hasty tone of voice on the telephone may be the caller's first—and last—impression of your office.

Staffing. Is your staff adequately trained and does it perform within the limits of state laws? The physician's office staff is an asset if those with patient contact have been adequately trained and oriented. Employers are responsible for the negligent actions of employees under the doctrine of respondent superior. Questions which are asked during a Claims Prevention Survey include:

1. Do aides perform only those duties permitted by law? Some states, like California, have specific laws which define what a registered nurse, licensed vocational nurse, physicians' assistant, nurse practitioner, technician, or medical assistant can and cannot do. Permitting an unlicensed aide to prescribe or refill medications, give medical advice, or perform medical procedures reserved for licensed or certified professionals may subject the physician to civil, criminal, and malpractice penalties. Moreover, insurance policies do not cover damages awarded for injuries resulting from illegal acts.

2. Are basic office policies and treatment protocols or guidelines set down in written form? Protocols should be developed for procedures which must be

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are Director of the Department, and Director of Special Projects, respectively.

done without variation, such as preparing specimens for the laboratory. Guidelines are more appropriate when flexibility, individual judgment, or patient needs allow staff to adapt basic rules, such as when taking histories.

3. Has the physician determined that aides have had adequate training and experience to perform specific duties? Absent licensure and certification, a physician may be responsible for making this determination and documenting on-the-job instruction.

Office Policies. Do patients understand office policies before a problem develops or a dispute arises? A physician's policies about fees, billing, special charges, restrictions on medication refills, referral to other physicians, and related issues should be explained to new patients. Otherwise, misunderstandings can interfere with the physician-patient relationship.

An effective way to explain office policies is in an inexpensive patient information pamphlet which includes: information about the physician(s); billing policies, such as added charges for completing insurance forms, notice that laboratory, x-ray, and consultants' charges are not included in statements, policies concerning advance payments, installment payments, acceptance or nonacceptance of insurance assignments, and policy on unpaid accounts; what the patient should do in an emergency if the physician is not available; information about on-call coverage; and specific information about the patient's responsibilities in the physician-patient relationship.

Patient Questionnaires. Does the physician read the forms patients are required to complete? Many physicians use health history questionnaires to assist in an initial assessment. These forms can be very useful. When improperly or carelessly used, the forms become a malpractice hazard. Forms are most helpful when: 1. All spaces for information are filled or voided. A blank space next to questions about allergies, medications, and past medical problems, could mean that the patient did not know, could not remember, or could not spell the term. 2. Names of current and prior physicians and reasons for seeing them are requested. Current medications, including over-the-counter drugs, are recorded. Physicians should review forms the patient completes at the physician's request. Physicians are advised to pay special attention to entries which suggest the need for followup.

Patients often list their chief complaints on such forms, but then forget to mention all of them when they see the physician. If a patient indicates he suffers from a chronic disease, but denies seeing another physician or taking medication, the history may be inaccurate or overstated. Similarly, when a patient reports he sees an orthopedist for back pain, an ear, nose, and throat physician for allergy, or a psychiatrist for depression, but denies taking medication, it is advisable to question that individual further. He or she may have inadvertently omitted the information.

Physicians should address all inconsistencies and inaccuracies in any information a patient provides. On completion of the review, the physician should initial the form to indicate it has been considered.

Referred Patients. Do patients understand why they have been referred to a physician or why they are being

referred to another one? Physicians who accept patients on referral should insist on receiving adequate clinical information from the referring physicians. Surgeons and other specialists may want copies of past medical records or relevant portions of the hospital chart in order to have more information than customarily is provided informally over the telephone (and often not documented). Some physicians use a referral form which indicates, in addition to the reasons for the referral and pertinent medical history, the referring physician's specific requests for examination, treatment, or followup. A physician should explain to a patient the reasons for a referral. (*Medical Liability Monitor—Loss Minimizer*, November and December 1987. *Loss Minimizer's* author is David Karp, San Rafael, CA, a professional liability claims consultant.)

PHYSICIAN'S ASSISTANT CONVICTED OF CRIMINAL CHARGES

The conviction of a physician's assistant for conspiracy to distribute controlled substances, distributing controlled substances, and attempting to evade income taxes should be affirmed, a federal appellate court for Kansas ruled. The physician's assistant allegedly masqueraded as a physician at a clinic and prescribed drugs to patients using his employer's DEA number. He allegedly called in false prescriptions to local pharmacies, sent runners to pick up the drugs, and then used those drugs for illegal street sales. The government showed he earned approximately \$21,000 in 1979 and \$23,000 in 1980 from his illegal drug activity. He failed to report those amounts as income on his federal income tax returns. Affirming his conviction, the court said that even if some of the prescriptions may have been for valid medical reasons, his conviction should stand because he was not a physician and was not registered with the DEA. The court affirmed his conviction on the other counts as well. (*The Citation*, October 1, 1987, Volume 55, No. 12)

VIRGINIA'S CEILING UNCONSTITUTIONAL

The federal trial court which held unconstitutional Virginia's \$1 million ceiling on the recovery of damages has refused the state's request for reconsideration of the decision on *Boyd versus Bulala*. The court's original opinion, rendered in November 1986, construed the Seventh Amendment to provide plaintiffs in federal court the right to have a jury determine the amount of damages without limitation. Because the seventh amendment does not clearly apply to litigants in state courts, the federal judge went on to interpret Virginia's Constitution to extend the same guarantee. Virginia's own Supreme Court has not yet ruled on the constitutionality of the law, and the state's lower court decisions are split.

The underlying case involved severe neurological injuries sustained by a newborn as the result of the failure to perform a timely delivery. The \$8.3 million recovery included \$2 million in punitive damages and a \$1.7 million award to the infant's parents for "past and future medical costs until [the infant plaintiff] reaches 18 years of age," which the court refused to reduce even though the infant died six weeks after the trial.

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This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or

without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The

following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth, anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

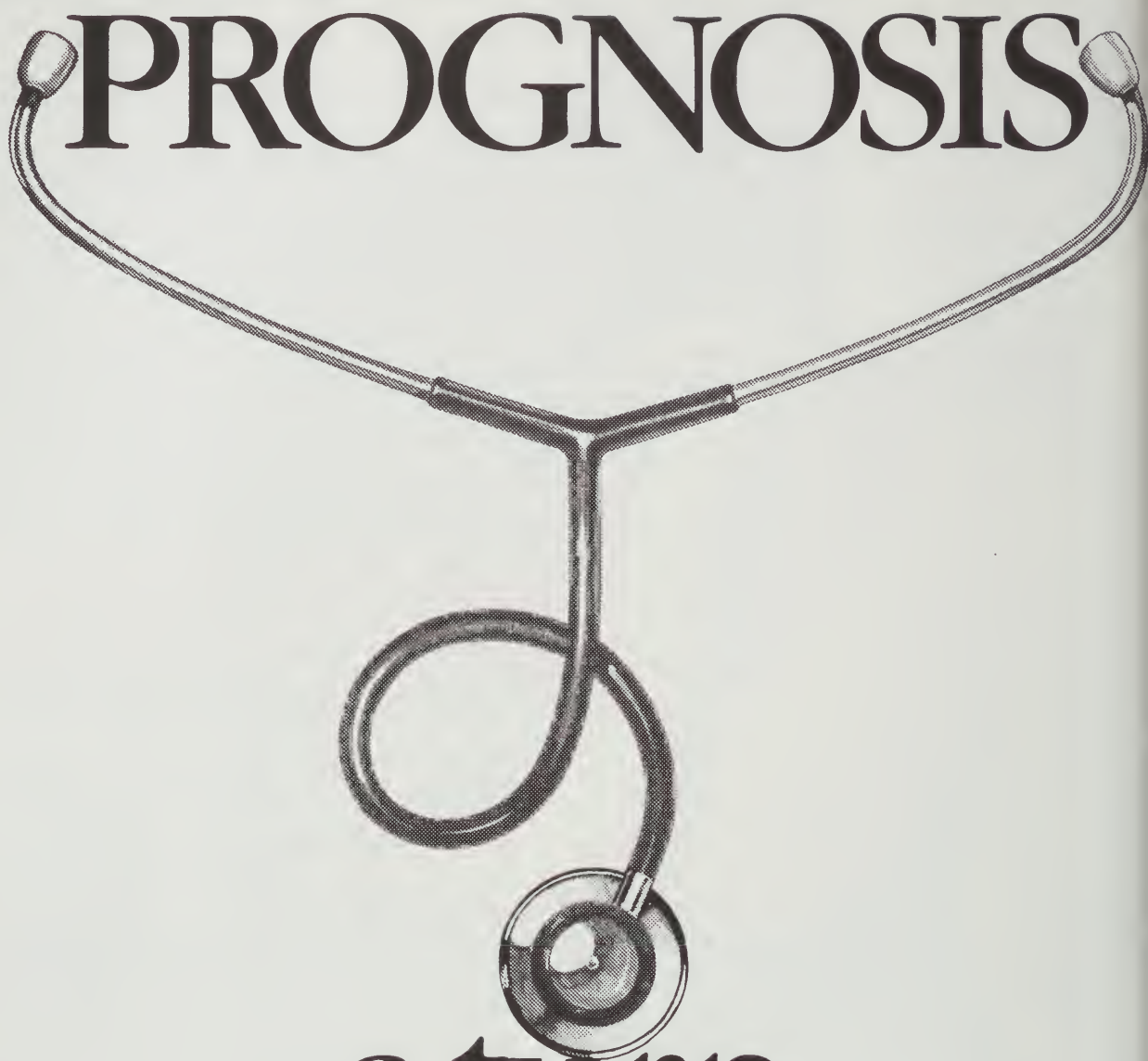
Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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THE NATIONAL BOXING SAFETY CENTER

MAX M. NOVICH, M.D., PERTH AMBOY*

Historically, New Jersey has been linked to boxing at all levels and has developed many champions.

The first million-dollar boxing gate was held at Boyles' 30 acres in Jersey City on July 2, 1921, when Jack Dempsey knocked out George Carpentier of France in the fourth round and retained his heavyweight championship crown. "Two Ton" Tony Galento of Orange, was a colorful boxer. Although short in stature and boxing finesse, he was full of unbelievable strength and courage. In his bout with the vaunted Joe Louis on June 22, 1939, he knocked Louis down to the floor in the second round; ultimately, Tony was knocked out by Louis in the fourth round. Jersey Joe Wolcott of Camden, former commissioner of boxing in New Jersey, had become world heavyweight champion when he defeated Ezzard Charles in the seventh round knockout on July 18, 1951, in Philadelphia. The list goes on and on with famous boxing names such as Rocky Graziano, Tony Zale, Ernie Schaaf, Don Petrin, Charles Fusari, and Sugar Ray Robinson. With the rejuvenation of professional boxing in Atlantic City, historic moments in boxing have taken place, i.e. the bout between Michael Spinks and Jerry Cooney.

THE PHYSICIAN IN BOXING

The first academic program on the medical aspects of boxing was held at UMDNJ-New Jersey Medical School on October 13, 1979, and has been followed by more boxing symposiums.¹⁻⁴

Because the medical profession so intimately is involved in boxing and because of recent bad press about boxing, the public has demanded boxing to be made safe. This appeared to be an opportune time to counteract the official position of the AMA, which was to abolish boxing.

In Las Vegas in January 1971, I founded the Association of Ringside Physicians for amateur boxing, which was incorporated in the State of New York on May 6, 1971, to ensure that amateur boxers in the United States and members of U.S. teams in foreign competition would be handled by U.S. physicians. The Association now is administered by the Sports Medicine Committee of the USA/Amateur Boxing Federation.

THE NATIONAL BOXING SAFETY CENTER

With the help of several key hospital administrative personnel and the blessings of the President and Chief Executive Officer, 16 physicians and a dentist organized the National Boxing Safety Center of the United Hospitals of Newark. The Medical Board is composed of specialists and an advisory panel of experts

including: an announcer, attorney, businessman, cutman, managers, marketing specialist, Newark City Councilman, physical educators, promoters, former championship contender, former U.S. Congressman, public relations expert, sports editor, sports psychologist, sports writer, and trainers. The Board has handled about 265 boxers; two have been disqualified for cardiac conditions, one for a detached retina, and one for blood dyscrasia.

The goals of the National Boxing Safety Center are:

- ★ To prevent unnecessary injuries with a multidisciplinary preflight examination determining whether a boxer is fit to box.

- ★ To assure boxing safety in the ring, an ongoing series of educational seminars for boxers, trainers, referees, and allied health personnel will be provided to enhance their ability to assure a contestant's fitness to box.

- ★ To provide followup care after every bout to determine if a boxer has sustained injuries; all boxers in the National Boxing Safety Center Program will be examined for injuries postfight.

- ★ To conduct research into the nature of boxing injuries in order to lessen their recurrence.

- ★ To make recommendations to governing bodies concerning administrative changes which would reduce boxing injuries and deaths in the ring.

CLINIC SERVICES

The Center's Clinic offers a battery of multidisciplinary medical tests to enable a physician to determine whether or not a boxer is medically fit to box professionally.^{5,6} These tests enable our physicians to identify existing problems in an applicant which might lead to an injury; the tests include: history and physical examinations; electrocardiogram, electroencephalogram, x-rays of the chest; laboratory examinations (CBC, blood type, blood chemistry, sickle-cell screening, VDRL, and urinalysis); eye examinations by our certified ophthalmologist; and neurological examinations. All results from laboratory and clinical examinations are listed on the form provided by the New Jersey State Athletic Commission.

Should any of these medical tests show an abnormality that might preclude a boxer from obtaining a license, the boxer is referred to a staff member for consultation. This consultant decides if this abnormality is valid or invalid. The medical examiner

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COVER STORY

then comments to the New Jersey State Athletic Commission as to whether or not the boxer applicant in question is medically fit to box professionally.

The response of our consultants has been most gratifying; they are sympathetic to boxers and to the sport of boxing, and the boxers are pleased that our physicians show such interest and concern. Our clinic is served by medical and nursing staffs and support systems including supervisors and administrative and public relations personnel.

In addition, we have a resident staff of orthopedic physicians who are being trained in sports medicine, the medical aspects of boxing, and the sport of boxing. This probably is the only such training program in the country. Managers and trainers visit the facilities to ask medical questions about their charges. Clinic fees are charged, and no boxer is turned away because of lack of funds.

THE NEW JERSEY STATE ATHLETIC COMMISSION

The State Athletic Commission has a responsibility to ensure the safety and welfare of boxers as follows:

- The Commission licenses boxers to assure that they are medically fit to box professionally.
- The Commission licenses and assigns referees, promoters, inspectors, seconds, and matchmakers.
- The Commission assigns licensed ringside physicians and a second physician in the dressing room. Postbout examinations are conducted by physicians; and, if necessary, treatment is performed by the physician in the dressing room or the boxer is referred to a local hospital emergency room.
- Inspectors oversee how handwraps and gloves are applied on a boxer in the dressing room. It is their duty to observe what methods seconds use to freshen boxers between rounds. Assigned inspectors are encouraged to go to gymnasiums to determine whether boxers are following appropriate pre-bout fitness and training routines. They also should attempt to detect training injuries which may be hidden from the physician at pre-bout examinations; to date, no such preliminary inspections have ever been sanctioned by state commissions.
- The Commission requires bonding of promoters and managers, termination of options, and monopoly of a boxer by a promoter, as recommended by the American Association for the Improvement of Boxing.⁷

TRAINING AND CONDITIONING

Boxing is an individualistic combative sport requiring courage and skills not possessed by the average male. The boxer must prepare himself with a thorough hardening and toughening process which takes years. It is this hardening of his body that will help prevent most injuries from the blows he will have to endure.

The modern concepts of exercise physiology were used by trainers of yesteryear: the trainers developed many of the concepts through trial and error. Strength, speed, and stamina are developed by the physiologic overload principle, which utilizes graduated muscular exercises and interval training.

Interval training builds speed and endurance by overloading an athlete through aerobic and anaerobic exercises which develop a high oxygen debt. A quick recovery of the cardiovascular and respiratory system is sought and expected. Weight training for conditioning requires exercises that will develop muscular power and muscular endurance. Interval training is developed progressively in each boxer. While the boxer is being conditioned, the trainer teaches him offensive and defensive boxing skills. As a rule of thumb, 15 rounds of daily training are required for each round of a projected bout.

Roadwork, the single best conditioner in the boxer's training program, involves jogging three to five miles daily to develop stamina and endurance. A boxer usually does his roadwork in the morning before breakfast. Most boxers break up the roadwork with footwork by moving the hands, arms, and trunk simultaneously.

A training boxer must spar with adversaries. Candidates for boxing are introduced to the basic elements of position, punching, offense, and defense. Then the boxer learns how to deliver the blow, while at the same time protecting himself from his opponent's counterblows. Hundreds of hours of hands-on instruction are required.

Gym work includes heavy and small bag punching. The heavy bag develops leverage of the boxer's punch and muscle control, and its resistance increases the size and strength of muscles of the shoulders and upper extremities. Punching the small bag develops speed, rhythm, timing, coordination, and strength to keep hands high. Rope-jumping (skipping) is an excellent cardiovascular, respiratory, and aerobic conditioner. This exercise prevents muscle stiffening and helps develop endurance. Gym work also employs calisthenics for stretching and flexibility, and shadow boxing entailing offensive and defensive moves in front of a full-sized mirror or in the ring.

A boxer's trainer must understand nutrition and be able to impart this information to the boxer. In addition, he must be aware of the protein myth, carbohydrate loading, and the importance of water and electrolyte balance.

A TYPICAL WORKOUT

The workout starts in the afternoon with an exercise to limber muscles and joints. All parts of the musculoskeletal system (including the neck, shoulders, trunk, and upper and lower extremities) systematically are put through a normal range of motion. The cardiovascular and respiratory systems are exercised for two or three rounds, and the boxer experiences slight diaphoresis. This exercise tones the musculoskeletal system while increasing the heart rate. A shadow boxing routine usually follows, and then a session of sparring with a partner begins. Instructions by the trainer are given during the end of each round. The session is concluded by floorwork (calisthenics) to strengthen abdominal muscles (sit-ups), the neck (bridging), and the legs (bicycling).

COVER STORY

THE HAZARDS OF BOXING

Kaplan reported that, despite the many punches thrown in a boxing bout, only about ten pivotal punches may land.⁸ Most blows miss, or are deflected, blocked, or parried. A punch that is not seen causes the most damage. Deaths in the ring are few and considerably less than in other sports.⁹ In boxing, there are 0.13 deaths per 1,000 participants, compared to 0.3 deaths in college football; 0.7 deaths in motorcycle racing; 1.1 deaths in scuba diving; 5.1 deaths in mountaineering; 5.6 deaths in hang-gliding; 12.3 deaths in sky diving; and 12.8 deaths in horse racing. Catastrophic paraplegia and quadriplegia occur in football, but never are seen in boxing. Since 1904, with the rebirth of the modern Olympics, there never has been a death or serious injury in Olympic boxing. Although the public is entitled to a good match and abhors a mismatch or tragedy in the ring, most ring deaths stem from administrative error.

The American Medical Association resolved to reduce brain injury in boxing; a panel of experts recommended changes in the present medical examinations and ringside coverage of boxers. This group included a cardiologist, general surgeon, neurologist, neurosurgeon, neuropathologist, neuroradiologist, and orthopedist. Only two members of this group had many years of actual ringside physician experience; the other physicians became acquainted with boxing by reading past and current national and foreign boxing literature. After 18 months of discussion, the physicians felt boxing should not be outlawed. They sponsored a successful educational conference on February 19, 1983, entitled, "The Medical Aspects of Boxing," in affiliation with the Association of Ringside Physicians.

The past 25 years have seen tremendous growth in sports medicine knowledge. Only recently has the boxing profession started to use these concepts. Some safety measures, such as the thumbless glove, have been used to reduce the incidence of retinal detachments and other eye injuries. Research on a mouthpiece to afford dental protection, to make breathing easier, and to provide more oxygen for fatigued muscles is being pursued.^{10,11} Hopefully, this new mouthpiece also will reduce the punching power to the brain and lessen knockouts.

Mismatches never should occur. A ringside physician should be authorized to stop a bout and de-

termine the competence of a boxer as he sees the match unfold. Physicians, referees, and judges should attend medical symposia and seminars to better acquaint them with injuries, knockdowns, and knockouts. The referee and ringside physician should have prearranged voice and hand signals so a doctor is called immediately when a boxer is in trouble.

The American Academy of Neurological and Orthopaedic Medicine and Surgery board certification for ringside physicians is a giant step in the right direction for reducing injuries and making boxing safer.

CONCLUSION

John Branca, former Commissioner of the New York State Athletic Commission, stated that there has to be professionalization of the boxing profession in the United States,¹² which can be executed as follows:

1. Congress must establish a regulatory agency professionally staffed with those meeting civil service qualifications, and adequately financed so that the mandates, regulations, and rules can be effectively and efficiently administered. The office staff must be qualified by education, training, and experience; to have been involved in boxing is not enough.

2. The National Boxing Commission must be vested with the sole direction, management, control, and jurisdiction over boxing and related activities.

3. All persons involved with boxing—corporations, promoters, referees, judges, matchmakers, timekeepers, box office employees, ticket takers, inspectors, doormen, ushers, professional boxers, their managers, trainers, seconds, sparring mates, announcers, gym owners, operators, and special police—must be licensed.

4. The national body must establish rules, regulations, and standards for all individuals involved in the boxing profession. All applicants must complete a personal application form and submit to fingerprinting, which will be on file with the National and State Boxing Commission. The National or Local Boxing Commission must provide training courses, medical seminars, and boxing safety conferences and require mandatory attendance for license approval and renewal.

5. The Commission must establish requirements for each job classification, including trainers, managers, judges, seconds, promoters, and boxers.

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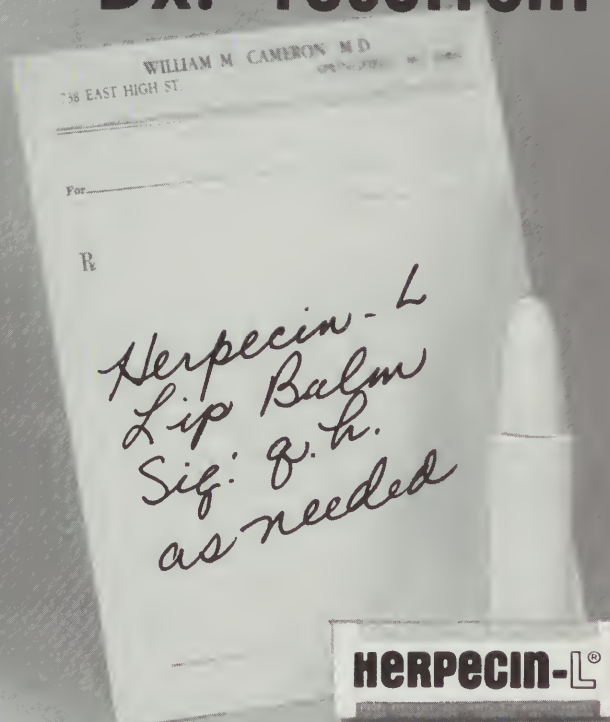
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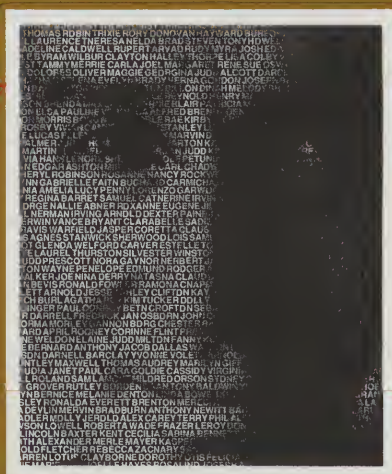
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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL® LA brand of propranolol hydrochloride (Long Acting Capsules)

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. **Hypertension:** INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. **CARDIAC FAILURE:** Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T₄ and reverse T₃, and decreasing T₃.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. **GENERAL:** Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL (propranolol HCl) is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytin, phenobarbital, and rifampin accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and lidocaine have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T₃ concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasisiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—Dosage must be individualized. Starting with 80 mg INDERAL LA once daily dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—Dosage must be individualized. The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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Reference:

1. Data on file, Ayerst Laboratories.

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CORONARY ARTERY DISEASE IN A YOUNG WOMAN WITH SLE

BRUCE J. HAIK, M.D., AND JACOB I. HAFT, M.D., NEWARK*

Chest pain in a young female with systemic lupus erythematosus (SLE) usually is due to pericarditis or pleurisy. Our 30-year-old patient with SLE and chest pain was found to have severe coronary disease on coronary arteriography. Occlusive coronary artery disease commonly occurs in young patients with SLE.

Chest pain in young women with systemic lupus erythematosus (SLE) usually is due to pericarditis or pleurisy.¹⁻³ Occasionally, however, the pain is due to myocardial ischemia and significant coronary atherosclerosis is found on arteriography or at post-mortem examination.¹⁻⁵ We present a report of a 30-year-old female patient with angina and extensive coronary occlusive disease, as shown by coronary angiography, to draw attention to the recent appreciation of the fact that coronary atherosclerosis occurs frequently in young patients with SLE, and should be suspected as a cause for chest pain in patients with SLE.¹⁻³

CASE REPORT

A 30-year-old woman was admitted to Saint Michael's Medical Center for elective coronary arteriography. Fifteen years earlier, she was diagnosed with SLE manifested by an acute systemic illness with fever, fatigue, facial rash, arthritis, and renal insufficiency. After serologic confirmation of the diagnosis, she was placed on maintenance prednisone therapy, but an exacerbation occurred with nephrotic syndrome and hyperlipidemia. Two renal biopsies showed membranous nephritis and proliferative nephritis, respectively. The patient developed hypertension, which was controlled with diet, but nine months prior to hospitalization, she experienced retrosternal tightness with radiation to

both arms which was precipitated by moderate activity and exposure to cold weather. Her pain lasted 15 to 30 minutes and sometimes was associated with shortness of breath, palpitations, and diaphoresis, but she denied paroxysmal nocturnal dyspnea, orthopnea, or pedal edema. Over the past two months, the symptoms increased in frequency and severity. A thallium stress test revealed a fixed defect in the posterior and inferior left ventricle walls after exercising for 5 minutes and 12 seconds. The patient stopped because of fatigue, but there was no chest pain or electrocardiographic changes of ischemia. She was admitted for coronary angiography.

In 1979, the patient had small bowel gangrene secondary to an arterial embolus and underwent small bowel resection. The postoperative course was complicated by acute renal failure and respiratory insufficiency requiring temporary hemodialysis and tracheostomy. She underwent total hysterectomy and bilateral oophorectomy because of menorrhagia in 1983. The patient's mother died of a myocardial infarction at the age of 44. There was no history of ethanol abuse;

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however, she has smoked two packs of cigarettes per day for approximately 15 years.

Examination revealed a moderately obese female in no distress. The temperature was 98.8°, pulse was 80 and regular, and respirations were 16. Blood pressure was 110/70. No rash or lymphadenopathy was present. The carotid pulses were normal without bruits. The lungs were clear. The point of maximum impulse was displaced laterally and the heart sounds were normal without murmurs, gallops, or rub. The abdomen was negative and the extremities were without cyanosis or edema. Peripheral pulses were present and equal bilaterally. Urinalysis was negative. The Hgb and Hct were 13.3 gm/dl and 39.5 percent with a platelet count of 292,000 and WBC of 3,700. The BUN was 9 mg/dl, creatinine was 0.6 mg/dl, glucose 109 mg/dl; electrolytes were normal. The serum cholesterol was 276 mg/dl.

An electrocardiogram showed normal sinus rhythm with an intraventricular conduction defect. Chest roentgenogram revealed an enlarged heart. Left heart catheterization and coronary arteriogram revealed akinesis of the inferior and posterolateral segments of the left ventricle with moderate to severe hypokinesis of the anterior and anterolateral segments. The left anterior descending artery had intraluminal disease throughout its course, with a large diagonal branch having an 85 percent narrowing shortly after its origin. The left circumflex artery revealed a 95 percent proximal narrowing and a large obtuse marginal branch had intraluminal disease. The right coronary artery had diffuse disease in its midportion and was totally occluded at its distal portion before the posterior descending artery (PDA). The PDA and posterolateral branches were filled via collaterals from the left coronary artery. Although surgery was considered, the patient preferred a trial with medication. She responded to diltiazem 30 mg four times a day and isosorbide dinitrate, 10 mg four times a day, and currently is being followed as an outpatient.

DISCUSSION

Systemic lupus erythematosus (SLE) can affect the heart in a number of ways.^{1,3} As part of the polyserositis associated with the disease, pericarditis is the most common cardiac manifestation.^{1,4} Pericardial effusion frequently is present, especially if investigation includes echocardiography, but only very rarely does tamponade occur.^{1,3} Myocarditis and a peculiar type of noninfective endocarditis with verrucous vegetations (Libman-Sacks endocarditis) are found frequently at autopsy but these forms of cardiac involvement rarely cause clinical problems.^{1,2,4} The myocardiopathy rarely causes cardiomegaly and heart failure, but these manifestations are difficult to separate from the effects of hypertension, anemia, or renal failure that frequently are associated with SLE.² Immune complexes in the myocardium have been reported by some investigators.⁵ Libman-Sacks-type vegetations rarely have been implicated as a cause of aortic or mitral insufficiency and rarely have resulted in emboli to the coronaries or other beds in the systemic arterial system.^{1,2} Conduction disturbances and arrhythmias, attributed to focal myocarditis or small vessel vasculitis, also have been reported.^{1,2}

Coronary artery disease was considered a rare complication of systemic lupus erythematosus until recently. In a report of 83 patients with lupus and a review of the literature to 1959, Shearn suggested that the occasional myocardial infarction seen at autopsy probably was due to vasculitis and that the atherosclerosis seen probably was incidental.⁶ Subsequently, a number of case reports of myocardial infarction in young patients with SLE began to appear⁷⁻⁹ and a different series of patients with the disease who had premature coronary atherosclerosis were reported.^{4,10-12} In 1975, Bulkley and Roberts reported 8 of 18 patients who received steroids for more than one year to have occlusive atherosclerosis in at least one coronary artery; 4 of the 8 patients had myocardial infarctions.⁴ None of the 17 patients treated with steroids for less than one year had coronary atherosclerosis. They hypothesized that accelerated atherosclerosis possibly was related to the higher incidence of hypertension seen in patients on steroids. A subsequent study from the National Heart Institute by Haider and Roberts found a similar incidence of occlusive coronary atherosclerosis with 10 of 22 autopsied patients having at least one of their major coronaries narrowed by greater than 75 percent.¹¹ The ages ranged from 18 to 36 years and 9 of the 10 patients were women. From the literature until 1985, Doherty and Siegel collected 33 cases of coronary artery disease in patients with SLE under age 35.² Twelve patients had definite atherosclerosis, 7 patients had coronary arteritis; the coronary artery disease in the others was not fully characterized. Badui found 16 percent of 100 female patients to have symptoms and signs of ischemic heart disease; 11 patients had electrocardiogram changes of transmural myocardial infarction.³ The patients were divided into two groups: patients thought to have coronary artery disease secondary to vasculitis, with angina associated with exacerbations of systemic lupus erythematosus activity elsewhere and responding to steroid therapy (5 patients), and patients with atherosclerosis, in whom steroids were not effective, who had disease of longer duration and who had no evidence of vasculitis elsewhere at times of increased angina activity (11 patients).

The incidence of coronary artery disease reported as a cause of death has varied. Rosner et al. reported myocardial infarction to have been the cause of death in 3 percent of 222 patients with systemic lupus erythematosus who died.¹³ Among a series of 29 such patients who died, Correia et al. reported 5 (17 percent) patients to have died of ischemic heart disease.¹⁴ Wallace et al. did not specifically identify coronary disease but noted that 25 percent of 82 patients with SLE in their series with nephritis and 30 percent of 46 patients without nephritis who died, had cardiovascular disease as the cause of death.¹⁵

The mechanism whereby young women with systemic lupus erythematosus develop coronary atherosclerosis remains unknown. Recent work has suggested that endothelial trauma may start a reparative process that leads to development of atherosclerotic plaques.¹⁶ The widespread arteritis of SLE erythematosus may damage the endothelium sufficiently to initiate this process even if the vasculitis is not severe enough to directly result in symptoms. Vasomotion also may play

a role in the etiology of atherosclerosis, with spasm causing endothelial damage. Vascular irritability and localized spasm, most notably Raynaud's phenomenon, is not uncommon in patients with SLE. Clotting abnormalities with hyper-reactive platelets also have been implicated as a cause of atherosclerosis. Antigen-antibody complexes and lupus-type anticoagulant, which is associated with a high incidence of thromboembolism, may make the young patient with SLE more prone to atherosclerotic coronary artery disease.¹⁷ In addition, these abnormalities may make the patient more sensitive to conventional risk factors such as smoking, high serum cholesterol, and hypertension, as was seen in our patient. The usual treatment with steroids may induce or worsen systemic hypertension.⁴

CONCLUSION

Although the mechanism remains obscure, atherosclerotic ischemic heart disease is not infrequently present in young patients with SLE; that diagnosis should be considered in patients with SLE with chest pain. As in our case, these patients may respond to conventional treatment for coronary artery disease.

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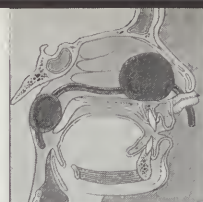
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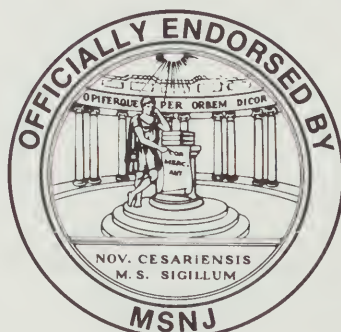
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THE GENOGRAM'S CONTRIBUTION TO FAMILY-CENTERED CARE

JOHN ROGERS, M.D., M.P.H., AND PETER COHN, M.D., PISCATAWAY*

A community-based study of the family genogram documented that more family information is obtained by genograms than by routine histories. The genogram also was associated with changes in physician behavior, such as more frequent inquiries about family issues.

One of the markers of family-centered care is the extent to which family information is gathered from patients and applied to clinical problems. The family genogram (Figures 1 and 2) is an expanded pedigree tree and is promoted as an efficient tool for collecting, recording, and retrieving pertinent family information.¹ Despite its use in family practice residency programs, the genogram appears to be used infrequently by physicians in community practices.² One possible reason for this low utilization may be the lack of empirical data demonstrating that genograms provide physicians with more family information than routine family histories, and that the presence of any additional information influences clinical encounters. A study in an academic family practice center documented that for new patients, genogram interviews obtain much more information than routine unstructured family histories.³ To date, however, there has not been a similar study of the genogram in the community practice setting nor an investigation of the genogram's impact on clinical care.

This community-based study compares family information obtained by genograms with that obtained by physicians in their usual manner during patients' first visits to the practice. The primary hypothesis is that genograms will produce more information about more family members than the physicians' routine family

histories. The second purpose of the study is to determine if the genograms influence physicians' behaviors during these initial encounters with patients. The hypothesis is that genograms will increase the frequency of these physician behaviors: exploration of family issues, request for interviews with other family members, and offers or referrals for therapy for emotional problems.

METHODS

The site of the study was a rural community with a population of approximately 5,000 persons. Four independent practitioners (two family physicians and two general internists) participated in the project. All new patients over 16 years of age presenting to these physicians during July and August 1985 were eligible for the study. These initial doctor-patient encounters were systematically observed by one of the investigators after training and standardization of the data collection forms. The observer recorded each patient's demographic information and chief complaint, and noted whether the physician explored a family problem

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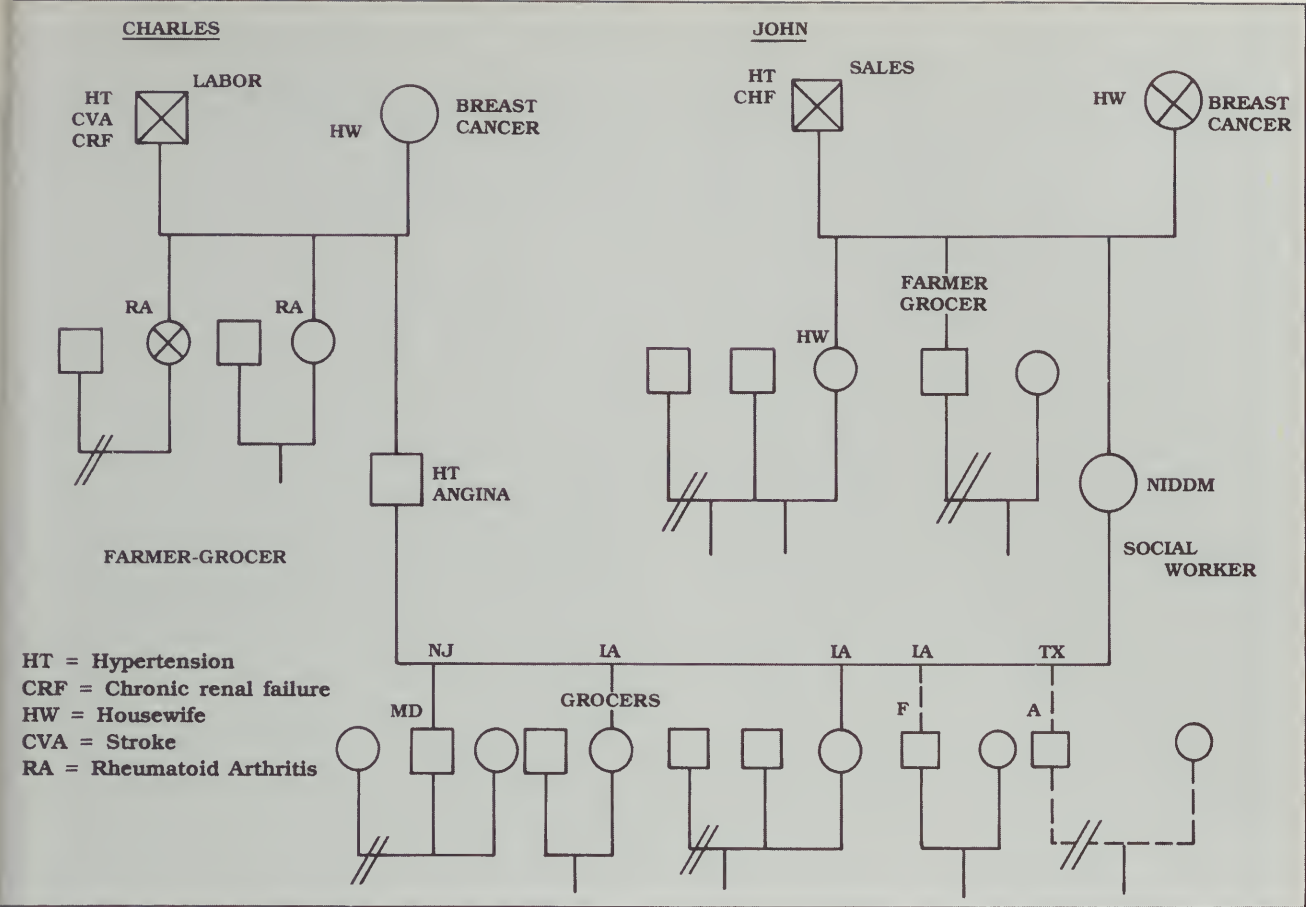


Figure 1—Author's family genogram showing basic family structure, life events, and repetitive patterns. Note that author is the oldest child, married with no children, living away from his family, and at particular risk for cardiovascular diseases.

or issue, requested interviews with other family members, suggested or offered counseling, or referred the patient for counseling. The observer also recorded whether the physician explored any job issue as an indicator of the physician's general inquiry about patients' social environments. The operational definition of "exploring an issue" was at least two questions about the same problem or issue. The observer also recorded any family information obtained by the physicians on a genogram recording form.

These data forms were completed for several routine first visits to each participating physician before the

introduction of the family genogram into the clinical encounters. After these baseline visits, the new patients completed self-administered genograms with assistance in the waiting room prior to the visit with the physician. These patients were divided into two groups: 1) feedback group—physicians received the genograms just before entering the examination room and 2) no feedback group—the genograms were placed in patients' records after the visits were completed. The assignment to the feedback and no feedback groups was done on an alternating basis without replacement for refusal to participate in the study.

TABLE 1
Demographic Characteristics of Study Sample

	Genogram Visits		
	Baseline Visits N=22	Feedback N=29	No Feedback N=21
Age			
Range	17-79	19-80	18-79
Mean	48.2	51.3	42.2
Median	53	52	46
Sex			
Male	11	19	11
Female	11	10	10

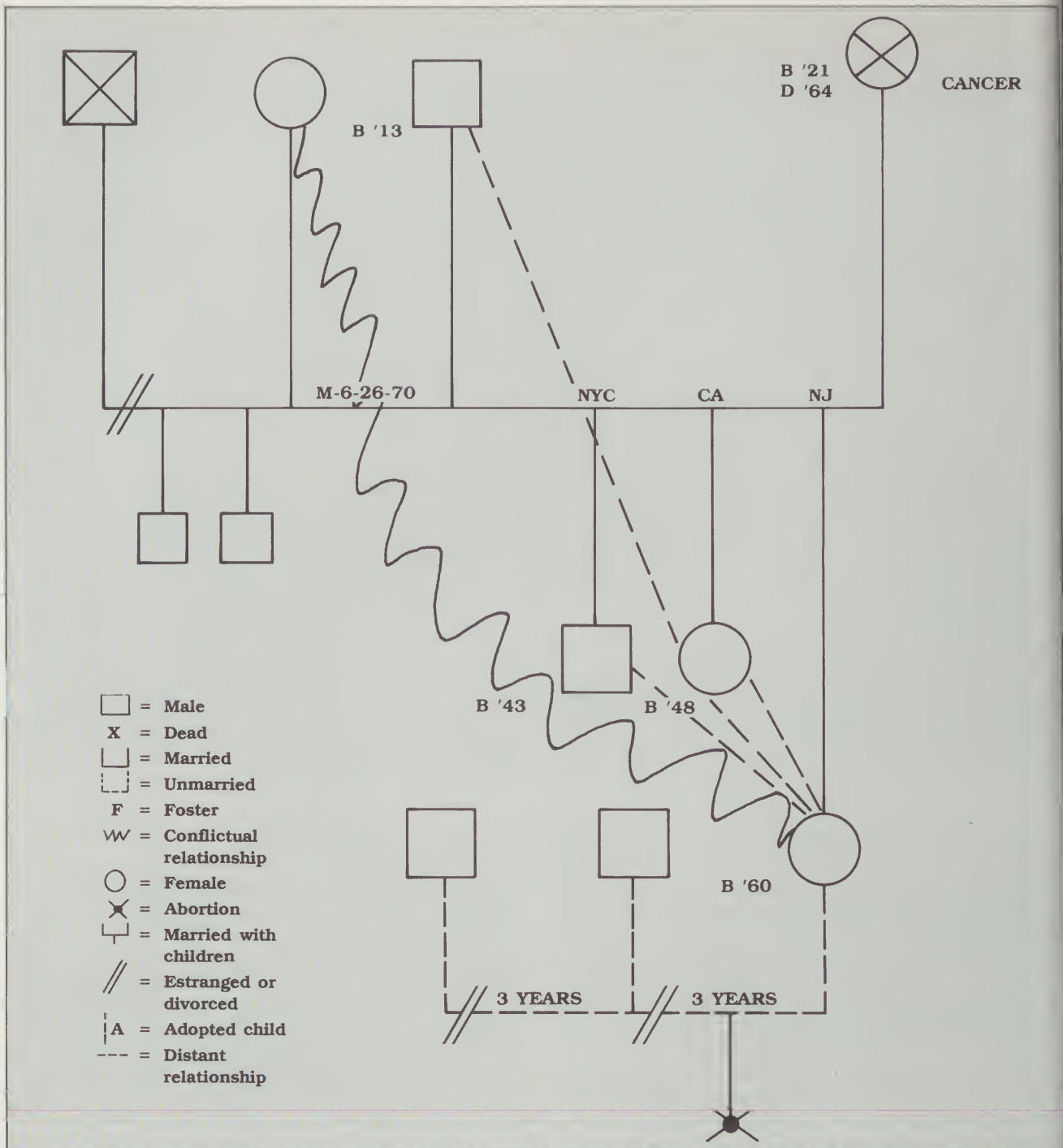


Figure 2—Brief genogram of patient with chronic pelvic pain. Note that her mother died when she was 4 years old, she is emotionally isolated from her family, and she has had two failed long-term relationships and one elective abortion.

The genogram recording forms were the same for the baseline visits and the genogram visits (feedback and no feedback groups). These forms were reviewed to determine how frequently different categories of family information were available to the physicians. Four types of information were included in the analysis: 1) family structure, number of generations for which information was available; 2) life events, major family stresses experienced by patient; 3) repetitive patterns, familial and genetic disorders; and 4) current household, current members and character of relationships.⁴ For "family structure," a generation was counted as present if there was at least one piece of information about at least one member on the genogram recording

form. A "life event" was noted as present if there was any indication that the identified patient had experienced marital separation or divorce, the birth of a child, or the death of a parent, sibling, child, or spouse. Credit for "repetitive patterns" was given if at least one appropriate biomedical or psychosocial problem was noted for any family member on the genogram. Information about the "current household" was counted as present if the membership of the household was noted on the genogram form or if the character of a relationship involving the patient or another household member was noted on the recording form.

The major comparisons were made between the baseline and genogram visits with secondary analysis

involving the feedback and no feedback groups of the genogram visits. The comparisons were made on the four categories of genogram information and the physician behaviors observed during the encounters. The Chi square test of significance with Yate's correction was used for these categorical variables. A *P*-value of .10 or less was considered significant due to the exploratory nature of this psychosocial research.

RESULTS

Seventy-two of the 83 patients approached for the study agreed to participate. Seven of the patients were accompanied by other family members during the

visit, but these patients were evenly distributed among the three study groups. The age and sex distributions among the three study groups were comparable as well (Table 1). The reasons for the patients' visits are outlined in Table 2 and were evenly distributed among the three study groups.

Review of the family genogram data forms documented that the genograms (feedback and no feedback visits) captured more family information than normally obtained by the physicians (baseline visits) (Table 3). For nearly one-fourth of the baseline visits, no information about any family member was obtained by the physicians' unstructured family histories, and for 50 percent of these visits, the family information was limited to one or two generations. In contrast, 90 percent of the genogram histories included information about three or four generations of the family. Life events experienced by the patients also were identified more frequently during genogram visits than during baseline visits. In particular, divorce or separation of the patient was identified five times as frequently at genogram visits, birth of a child was identified 50 percent more frequently, and death of an immediate family member was identified nearly twice as frequently. The genograms identified biomedical problems among family members 94 percent of the time; whereas, the physicians' routine histories noted biomedical problems only 45 percent of the time. The routine histories did not detect any psychosocial problems among family members, but over 20 percent of the genograms noted a psychosocial problem in at least one family member. The patients reported psy-

TABLE 2	
Patients' Reasons for Initial Visits	
Reason For Visit	Number of Patients
Musculoskeletal Problem	36
Cardiopulmonary Problem	8
Hypertension/Diabetes	8
Headache	5
Rash	4
Gastrointestinal Distress	3
School Physical	3
Upper Respiratory Infection	2
Fatigue	2
Cancer	1

TABLE 3		
Categories of Family Information Obtained from Patients Comparison of Baseline and Genogram Visits		
Category of Family Information*	Baseline Visits N=22	Genogram Visits N=50
Family Structure**		
One Generation	2 (9%)	
Two Generations	9 (41%)	3 (6%)
Three Generations	6 (27%)	27 (54%)
Four Generations		20 (40%)
Life Events		
Divorce/Separation+	1 (5%)	13 (26%)
Birth of Child+	10 (45%)	35 (70%)
Death of Immediate Member	6 (27%)	22 (44%)
Repetitive Patterns		
Biomedical Problems°	10 (45%)	47 (94%)
Psychosocial Problems+		
Family Members		11 (22%)
Patient	2 (9%)	13 (26%)
Current Household		
Membership•	8 (36%)	41 (82%)
Character of Relationships	2 (9%)	10 (20%)
*See text for explanation of categories.		
**One or two generations versus three or four generations, <i>P</i> <.001.		
+ <i>P</i> <.10.		
° <i>P</i> <.01.		
• <i>P</i> <.001.		

chosocial problems for themselves three times as frequently during genogram visits than baseline visits. Finally, household membership was noted during 36 percent of baseline visits and 82 percent of genogram visits, and the character of at least one family relationship was determined at one-fifth of the genogram visits but only one-eleventh of the baseline visits. It is noteworthy that the two genogram groups are very similar on detection of all categories of family information, especially life events and repetitive patterns (Table 4).

With regard to the second purpose of the study, family issues were explored during 32 percent of the genogram encounters and during 14 percent of the baseline encounters, but this trend was not statistically significant (Table 5). During the genogram-feedback visits, the physicians looked at 27 (93 percent) genograms and reviewed 15 (55 percent) genograms with the patients for clarification. However, there was no difference between the feedback and no feedback groups on the exploration of family issues at 31 and 33 percent of visits, respectively. Results for requesting interviews with other family members and exploring job

issues were similar with little difference between the feedback and no feedback groups but with an apparent increase of genogram over baseline encounters (Table 5). There were no suggestions, offers, or referrals for counseling noted during any of the study encounters.

DISCUSSION

To our knowledge, this is the first intervention trial of the genogram in the community setting. The study's major limitations are the rather small number of subjects, the use of a potentially biased observer for data collection, and the involvement of only four physicians. Some of the study's results are similar to those of other investigations of psychosocial issues in primary care, so this project may provide us with some useful lessons. For example, the rate of exploration of family issues in the genogram visits (32 percent of visits) is within the range noted by others (29 to 75 percent of visits).^{5,6} In addition, the lack of psychosocial counseling or referrals observed in this study is consistent with the low rates for these behaviors in primary care previously described by others (4 to 5 percent of visits).^{7,8}

TABLE 4
Categories of Family Information Obtained from Patients
Comparison of Feedback and No Feedback Visits

Category of Family Information*	Genogram Visits	
	Feedback N=29	No Feedback N=21
Family Structure		
Two Generations	1 (3%)	2 (10%)
Three Generations	15 (52%)	12 (57%)
Four Generations	13 (45%)	7 (33%)
Life Events		
Divorce/Separation	7 (24%)	6 (29%)
Birth of Child	23 (79%)	12 (57%)
Death of Immediate Member	15 (52%)	7 (33%)
Repetitive Patterns		
Biomedical Problems	27 (93%)	20 (95%)
Psychosocial Problems		
Family Members	9 (31%)	2 (10%)
Patient	8 (28%)	5 (24%)
Current Household		
Membership	22 (76%)	19 (90%)
Character of Relationships	6 (21%)	4 (19%)

*See text for explanation of categories.

TABLE 5
Comparison of Study Groups on Physician Behaviors

Physician Behavior	Baseline Visits	Genogram Visits	
	N=22	Feedback N=29	No Feedback N=21
Explore Family Issue	3 (14%)	9 (31%)	7 (33%)
Request Family Interview	0 (0%)	1 (3%)	2 (10%)
Explore Job Issue	1 (5%)	4 (14%)	5 (24%)

The study's first hypothesis that the genogram will produce more information about more family members than physicians' routine family histories was supported by the data. Information about three or four generations of family members was available at 90 percent of the genogram visits, but only 27 percent of the baseline visits. The genograms also identified major family stresses nearly twice as often as the routine histories. Even information about biomedical problems in family members was captured over twice as often by the genograms than by the routine histories. The ability of genograms to detect psychosocial problems in family members and the identified patient was superior to that of the routine histories as well. Finally, household membership and the character of family relationships were noted over twice as frequently for genogram visits than for baseline visits. An obvious alternative hypothesis to the study hypothesis is that the baseline visit patients were very different from the genogram visit patients on the prevalence of life events and repetitive patterns. The demographic similarity among the three study groups and the similarity between the two genogram groups (feedback and no feedback) on all family information categories argue against this alternative hypothesis. In addition, only the superior data gathering ability of the genogram over the routine history could account for the differences noted for the "family structure" and "household information" categories. The only other viable alternative to the study hypothesis is a systematic reporting bias by the observer. This threat to internal validity cannot be completely ruled out in this situation, but the substantial differences between genogram and baseline groups would require almost deliberate distortion during data collection. Hence, it is accepted that genograms gather more data than routine histories. This confirms a previous study conducted in a family practice residency program.³

The study's second hypothesis, that the genograms will lead to greater exploration of family issues, increased physician requests for interviews with family members; increased offers or referrals for therapy for emotional problems only partially was supported by nonsignificant trends. There were only three physician requests for interviews with other family members but no offers for referrals for therapy. These findings are not atypical for primary care encounters where interviews with other family members are rarely requested,⁵ mental problems are diagnosed half as often for new patients as compared with established patients,⁹ and psychosocial counseling referrals occur in less than 5 percent of encounters.^{7,8} The physicians did explore family issues more frequently during genogram visits than baseline visits, and the feedback and no feedback groups were equal on this outcome. It is of great interest that the physicians' behavior appeared to be

influenced regardless of whether they had the genogram in their possession during the visit or not. This result is similar to those of studies using the General Health Questionnaire (GHQ) as a psychosocial screening tool in that the feedback and no feedback groups were not different on the recognition and treatment—counseling, drugs, and referral—of mental problems.^{8,10} Unlike this study, the GHQ studies did not include baseline visits, so they could not compare the physicians' behavior during feedback visits and baseline visits before the intervention.

There are two possible explanations for the apparent change from baseline to no feedback visits: general changes in the physicians' behavior once the trial began or changes in the patients as a result of completing the genogram, which indirectly influenced the physicians' behavior. There is evidence supporting the general change in the physicians' concern with the patients' social environments as indicated by the modestly increased exploration of job issues during genogram visits. While there is no direct evidence support-

ing the possible explanation that the results are due to changes in the patients, research suggests how this may be feasible. Specifically, physician recognition of family difficulties has been shown to be related to patient attitude about the appropriateness of seeking help for psychosocial problems from primary care practitioners.¹¹ Completing genograms prior to seeing physicians may influence patients' attitudes about

the appropriateness of seeking psychosocial care from family physicians and general internists and thereby influence the doctor-patient relationship and the content of the clinical encounter. These possible explanations for the baseline—no feedback differences, i.e. changes in physicians or patients—cannot be excluded or accepted at this point in our understanding of the issues.

This community-based study has confirmed that the genogram makes more family information available to the participants of initial doctor-patient encounters than physicians' routine family histories and suggests that the genogram may influence the physicians' behaviors during those visits. Additional studies now are needed to determine whether the genogram improves the recognition and treatment of psychosocial problems, particularly family difficulties, and has any other beneficial impacts on clinical care. A fundamental tenet of family medicine is that family-centered care enhances physicians' "capacity to help."¹² This assertion or hypothesis must be tested by empirical research. The family genogram provides one standardized way of operationally defining family-centered care by categorizing the types of family information available to physicians during clinical encounters. The ways in which the family information is used in clinical decision making and influences clinical care

***The study showed that
genograms produce more
information about more family
members than routine histories.
Genograms also identified major
life stresses nearly twice as
often as routine histories.***

then can be documented to address the basic research question, "Does family-centered care make a difference?" The use of the genogram in addressing this question appears to have merit and further research is warranted.

SUMMARY

Four primary care physicians and 72 patients participated in an intervention trial of the family genogram in a community setting. The results supported the first of the study's two hypotheses: genograms will produce more information about more family members than physicians' routine histories, and genograms will lead to increased physician exploration of family issues. In addition, the study demonstrated that the family genogram can be used to categorize the family information physicians may gather during clinical encounters and may use in their problem solving. In this way, the genogram provides a standardized way to operationally define family-centered care and thereby provides a method for empirically testing the fundamental family practice tenet that a family focus improves clinical care.

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Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.

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REVIEW: INFECTIOUS DISORDERS OF THE PAROTID GLAND

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Infections of the parotid gland can be caused by many different organisms including bacteria, viruses, and mycobacteria. These entities must be identified and malignancy must be ruled out. Once the specific organism is identified, therapy may be instituted.

Parotid gland enlargement has many etiologies; therefore, the diagnosis and treatment represents a medical challenge. One must always consider malignancy in the differential diagnosis since 10 percent of patients with a parotid mass have this problem (Table).

In the early 20th century, postsurgical bacterial parotitis was a well-recognized entity, with surgical drainage as its sole therapy.¹ From the 1940s to the early 1950s, surgical parotitis was almost nonexistent as a result of antimicrobial agents. Prematurely, Robinson labeled surgical parotitis, "a vanishing disease"² only to see a resurgence of this entity in the 1950s and 1960s, probably due to the emergence of sulfonamide-resistant *Staphylococcus aureus* and the advanced ages of patients admitted for surgical treatment.

PYOGENIC PAROTITIS

Suppurative parotitis usually presents with sudden onset of swelling, pain, heat, tenderness, erythema,³ cervical adenitis, and trismus. Fever, leukocytosis, malaise, and sepsis also are common in this disease. Fluctuation may not be detectable because of the concealing effect of the dense surrounding parotid fascia.⁴ Purulent material may be seen draining from the parotid duct.

Pyogenic parotitis is more common in any chronic

debilitating condition, especially if dehydration and poor oral hygiene are present. Drugs used by the elderly, such as those for Parkinson's disease⁵ or diuretics⁶ predispose a person to parotitis by decreasing the flow of salivary secretions. In the absence of bacteriostatic mucous in the parotid ductal system and decreased flow, retrograde infection may develop.⁷ Other medications, such as antihistamines, tranquilizers, and antihypertensive agents⁸ also can predispose to xerostomia and parotitis.⁸ Decreased salivary flow and retrograde infection are associated with ductal obstruction caused by stones, connective tissue disease, trauma, mucous plugging, and oral carcinoma. The drying effect of atropine on the oral mucosa predisposes the surgical patient to acute pyogenic infection. The best prognostic factors are the premorbid condition of the patient prior to surgery and the pre-existing predisposing disease.

Pyogenic parotitis can result from hematogenous seeding during bacteremic episodes, which usually presents as a parotid swelling during or shortly after an episode of septicemia.

The most common organism associated with pyogenic parotitis is *Staphylococcus aureus*,⁹ but many

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TABLE

Infectious Disorders of the Parotid Gland

Bacterial

Staphylococcus aureus
Streptococcus pneumoniae
Staphylococcus albus
 Anaerobes
Salmonella species
Proteus species
Pseudomonas species
Haemophilus influenzae

Chronic Granulomatous

Mycobacterium tuberculosis
Mycobacterium avium intracellulare
 Actinomycosis
 Cat-scratch
Francisella tularensis
 Brucellosis
 Rhinosporidiosis
 Histoplasmosis
 Hansen's disease

Viral

Mumps
 Coxsackie
 Epstein-Barr virus
 Influenza A.
 Parainfluenza Type 1 and 3
 Herpes simplex
 Cytomegalovirus
 Herpes Zoster
 Echovirus
 Lymphocytic-choriomeningitis virus
 Mycoplasma pneumonia

Noninfectious Cause

Sjögren's syndrome
 Systemic lupus erythematosus
 Allergy
 Mikulicz's disease
 Kimura's disease
 Hepatic disease
 Diabetes
 Malnutrition
 Hyperlipoproteinemia
 Calculi
 Dentures
 Iodine
 Chronic lead ingestion
 Hypothyroid
 Hyperuricemia
 Cystic fibrosis
 Wind

other bacteria have been reported including, *Streptococcus viridans*, hemolytic streptococci, *S. albus*, *S. pneumoniae* anaerobes, *Salmonella* sp, *Proteus* sp, *Pseudomonas* sp, and *Haemophilus influenzae*.

Infection begins in the larger ducts, destroys the ductal epithelium, and invades the remainder of the gland.¹⁰ This may lead to multiple abscesses, which

can coalesce and penetrate through the capsule, involving local tissue. Complications of pyogenic parotitis range from mild edema to fulminant glandular necrosis. Suppuration with and without osteomyelitis, fatal septicemia, facial nerve palsy, respiratory obstruction, and death are all sequelae of pyogenic salivary gland infection.³ Rupture through the floor of the external auditory canal, spontaneous drainage through the cheek, and extension to the face, neck, and mediastinum also have been reported by Spratt.⁷

The diagnostic evaluation requires a comprehensive history and physical examination. One must differentiate between enlarged parotid gland and local adenopathy and should attempt to palpate calculi and express pus from the parotid duct. Gram stain and culture of drainage from Stenson's duct or any other area of drainage can be of great value. X-rays of bony structures and soft tissue are needed to rule out osteomyelitis and calculi in the salivary ducts. Contrast sialography or probing of the duct may identify strictures or calculi. Radioisotopic scanning has been replaced by computerized tomography. Should a diagnosis prove elusive after this basic evaluation, biopsy with histology and culture should be performed. Laboratory technicians should perform gram stain and acid fast bacilli (AFB) smears and culture tissue for bacteria, virus, mycobacterium, and fungi.

In the preantibiotic era, mortality rates for acute parotitis ranged from 30 percent to 87 percent.^{1,2,11} Blair reported a 30 percent mortality in 1923 in a group of patients with bilateral parotitis treated without antimicrobials. Today's treatment with antimicrobials, nutrition, fluid management, and surgery has lowered mortality rates considerably.

Prior to the advent of antimicrobial agents treatment included radiation therapy, chewing gum, cannulation and irrigation of Stenson's duct, hot and cold packs, massage, and lemon drops⁷—all to no avail. Today, one should aim therapy at controlling pre-existing medical problems, provide adequate hydration, and discontinue all unessential medications. Failure to respond to medical therapy or development of fluctuation requires prompt drainage.

VIRAL PAROTITIS

Mumps (epidemic parotitis) is the most common viral disease affecting the parotid gland. The mumps virus is a member of the Paramyxoviridae¹² family which causes a systemic febrile illness with unilateral or bilateral nonsuppurative swelling and tenderness of the parotid gland. Prior to the advent of the mumps vaccine, epidemics occurred every two to five years,¹³ in January and May with 90 percent of those affected less than 14 years old.¹⁴

Within one day of the onset of fever, anorexia and malaise, earache, and parotid tenderness are present. Severe pain occurs during the period of rapid enlargement which reaches its maximum in two or three days. The gland is diffusely tender and swollen; the orifice of the parotid duct is erythematous and swollen, and exudes clear secretions.¹⁵ Extra-salivary gland manifestations include submaxillary adenitis, epididymo-orchitis, oophoritis, spinal fluid pleocytosis, meningitis, encephalitis, transient high-frequency deafness, and cardiac and renal abnormalities.

Diagnosis is aided by a history of exposure to mumps and by the clinical presentation. The white blood count either may be normal or reveal a mild lymphocytic leukopenia. Serologic studies or viral isolation may be of value when parotitis is recurrent or absent, a systemic illness occurs, or extra-salivary gland manifestations are present. Laboratory confirmation of mumps is not essential but is helpful, especially in adults; an increased serum amylase may be helpful.

The differential diagnosis of viral parotitis includes Coxsackie,¹⁶ mononucleosis,¹⁷ influenza A,¹⁸ lymphocytic-choriomeningitis virus,¹⁹ parainfluenza Type 3,^{20,21} parainfluenza Type 1, herpes simplex, cytomegalovirus, herpes zoster,¹⁵ and echo virus.²² These individual agents can be differentiated from mumps by serologic techniques or viral cultures.

Mycoplasma was described as a cause of parotitis.²³ Anderson pointed out the disease was demonstrated by acute and convalescent mycoplasma titers of 1:280 and 1:640, respectively.¹⁷ Mumps S and V titers were not elevated. The patient responded to treatment with tetracycline in six days.

Treatment of viral causes of parotitis is essentially symptomatic: analgesics and antipyretics, narcotic analgesics for severe orchitis, bed rest, and fluids. Intravenous fluids may be required for patients with severe vomiting or pancreatitis. Observation for complications such as hepatitis with cytomegalovirus or Epstein-Barr virus, and meningitis with herpes zoster virus, herpes simplex virus, mumps, cytomegalovirus, Epstein-Barr virus, and lymphocytic choriomeningitis, is essential.

GRANULOMATOUS PAROTITIS

The most common cause of granulomatous parotitis is *Mycobacterium tuberculosis* (M-TB). This specific parotid disease may or may not be associated with tuberculous pulmonary disease or with a positive tuberculous skin test. When classic findings of M-TB are present with a caseating granulomata and AFB, the diagnosis readily is made. When these findings are absent, the diagnosis is made by culture and a high degree of suspicion. Antituberculous medication is the mainstay of therapy; surgical intervention is indicated only if caseation necrosis occurs. In this case, complete surgical excision while the patient is under appropriate medication is necessary. Incision and drainage are not recommended at this point.²⁴ Tuberculous parotitis has many of the histologic features of sarcoid parotid disease; the presence of tuberculosis or sarcoidosis in other areas is as helpful as finding acid-fast organisms in the parotid tissue or culture.²⁵

Atypical acid-fast mycobacterium, causing infection of the parotid gland, has been described by Yarrington.²⁴ These infections are caused by scotochromogens and photochromogens. Because of their close associations with *Mycobacterium tuberculosis*, these infections can give a weekly positive PPD skin test, which may be diagnostically helpful.²⁴ Since these organisms are resistant to present antituberculous medication, complete surgical excision is necessary. This avoids the problem of fistula formation, often commonplace with incomplete excision. The new quinolones or rifampin-like compounds may be of some therapeutic value

in the future. Considering that *Mycobacterium avium intracellulare* (MAIC) is the most frequent organism recovered from the blood cultures of AIDS patients,²⁶ it will be interesting to see if the incidence of parotitis caused by atypical AFB increases in this group.

Actinomycosis also may cause chronic granulomatous disease of the parotid gland. Primary actinomycosis ascends from the mouth and usually involves the entire gland. If caused by a foreign body, it may involve only a portion of the gland. Secondary actinomycotic parotitis is due to infection from adjacent tissue, usually the cervicofacial actinomycosis.²⁷ Clinically, one sees chronic nodular induration with minimal to moderate pain. Fistulas draining yellow or white pus with yellow sulfur granules are common: erythema and induration of the orifice of Stensen's duct may be seen.

The diagnosis is established by positive cultures from pus or tissue, along with branching gram positive filaments and pin-head size sulfur crystals.

Actinomycotic parotitis is somewhat more stubborn than cervicofacial actinomycosis. It usually responds well to intravenous penicillin therapy for four to six weeks followed by 6 to 12 months of oral penicillin therapy. Surgery usually is not required. When used, however, surgery often is accompanied by complications.

Parotitis caused by cat-scratch disease is uncommon and can be difficult to differentiate from histiocytic malignancy, both clinically and histologically.²⁸ The disease usually presents with an enlargement of the regional lymph nodes, which drain the area of the inoculation site, with or without suppuration. Fever, rash, osteolytic bone disease, and neurologic manifestations have been described. The history of exposure to cats and a clinical picture consistent with cat-scratch disease are essential for an accurate diagnosis, but one must exclude all other diseases to be certain. The diagnosis can be supported by the demonstration of bacilli on Warthin-Starry silver stain. The skin test antigen is not commercially available at this time. Acid-fast bacilli smears, gram stain, and culture are essential to rule out tuberculous disease. This disorder is self-limiting and requires only careful observation. Surgical intervention is indicated only to rule out malignancy.

Blatt has reported granulomatous parotitis associated with *Francisella tularensis*.³⁰ Ulceration at the site of inoculation, as well as systemic manifestations of the infection, usually are present. Systemic manifestations consist of fever, chills, and malaise. A history of exposure to rabbit, tick bite, or exposure to other wild animals is extremely helpful. Diagnostic tools include cultures, agglutination titers, and skin tests. Other rare granulomatous diseases of the parotid gland are caused by rhinosporidiosis,³¹ brucellosis,³² histoplasmosis, and Hansen's disease²⁴ in the appropriate geographical areas. Syphilis always should be considered in the differential diagnosis of neck masses.³³

NONINFECTIOUS, BENIGN DISEASES

Other benign noninfectious causes of parotid enlargement include connective tissue diseases, metabolic and allergic disorders, Sjögren's syndrome,³⁴ lupus,³⁵ Mikulicz's disease,³⁶ Kimura's disease,³⁷ and sarcoid-

osis.^{38,39} Parotid enlargement due to alcoholism,⁴⁰ liver disease,⁴¹ diabetes,⁴² malnutrition,⁴³ iodine,⁴⁴ chronic lead ingestion, hypothyroidism, Cushing's syndrome, hyperuricemia, cystic fibrosis,⁴⁵ and hyperlipoproteinemia⁴⁶ must be ruled out. Allergic parotitis⁴⁷ and hypersensitivity reactions⁴⁸ are well described, including reactions to commonly used medications such as sulfa compounds⁴⁷ and phenylbutazone.⁵⁰ Parotid swelling, secondary to mechanical causes such as ductal obstruction caused by calculi or ill-fitting dentures⁵¹ also should be considered. An unusual consideration is the association of parotitis in patients who have a known history of some sort of forceful blowing. The entity of wind parotitis⁵² was described by Saunders after encountering four patients who played wind instruments or who had forcefully blown up heavy balloons.

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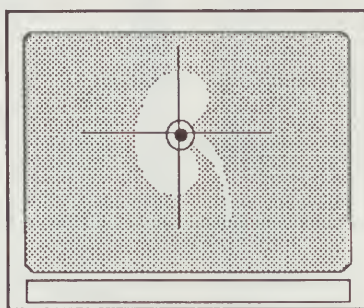
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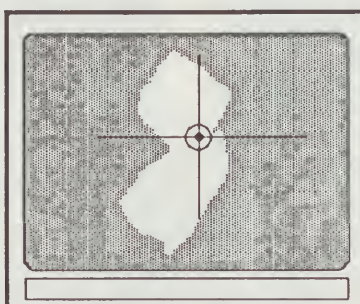
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You shouldn't have to go out of your way for lithotripsy services to complement your practice.

The New Jersey Kidney Stone Treatment Center is centrally located in New Brunswick, New Jersey, near statewide highways, for easy access for you and your patients.

The Center is equipped with the latest Dornier HM4 "tubless" lithotripter, which eliminates the need for a water bath. That means easier patient handling, and greater patient comfort.

And the Center is located at a major academic medical center, with full medical back-up. Patients are treated on an outpatient or inpatient basis.

Any board-eligible or board-certified urologist who has completed the ESWL training course and is licensed in the State of New Jersey may apply for privileges at the Center.

Physicians may also refer their patients to the Center for treatment by a member of our medical staff. After the procedure, patients are referred back to their own urologists for follow-up care.

For a credentialing package, or for more information about lithotripsy, call Center Director Diane DiGiulio at 1-800-542-8887, 8 a.m.-5 p.m., Monday-Friday.

New Jersey Kidney Stone Treatment Center

Located at Robert Wood Johnson University Hospital
One Robert Wood Johnson Place
New Brunswick, New Jersey 08901

The New Jersey Kidney Stone Treatment Center is operated by Health Horizons, (ESWL), L.P., affiliated with the following hospitals: Community Memorial Hospital, Freehold Area Hospital, Helene Fuld Medical Center, Jersey Shore Medical Center, Raritan Bay Medical Center, Riverview Medical Center, Robert Wood Johnson University Hospital, St. Francis Medical Center, St. Peter's Medical Center, Somerset Medical Center.

Trustees' Minutes; UMDNJ Notes; AMNJ Report; New Members; Physicians Seeking Location in New Jersey

Trustees' Minutes January 17, 1988

A meeting of the Board of Trustees was held on January 17, 1988, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Report of the President . . .

1. Medicaid Fees . . . Reported that legislative efforts to achieve appropriate Medicaid increases will be undertaken by the Society.

2. Legislative Committee—Medical Inter-Insurance Exchange of New Jersey . . . Noted that bills dealing with the two basic issues in tort reform, structured payments, and statute of limitations, had not been enacted in the previous session of the Legislature.

3. Task Force on AIDS . . . Noted that the Task Force will be developing a program for presentation at the 1988 Annual Meeting.

4. Senior Citizens Forum . . . Received programs from the third Senior Citizens Forum to be held on April 6, 1988, and noted the keynote address will be delivered by Senator John Kitzhaber, M.D.

5. Executive Committee . . .

a. State Commission of Investigation (SCI) Report on Impaired Physicians Program Update . . . Noted

the Executive Committee received a report from Mr. Maressa to be considered by the Board in Executive Session.

b. Foundation of UMDNJ Request for Funding . . .

Advised that a recommendation regarding a grant will be submitted for action to the Board.

c. Applications for Position of Editor of NEW JERSEY MEDICINE . . .

Noted that a subcommittee has been named to review applications for consideration by the full Executive Committee.

6. Legislation—Bill A-1591 . . . Indicated an interest in pursuing this bill which prohibits licensing by agency action; the bill stipulates that no category of health care provider shall practice or be licensed or certified to practice in New Jersey without statutory authorization.

7. Ad Hoc Committee on Women in Medicine . . .

Noted that special letters were sent to women physicians inviting them to join MSNJ and noted the importance of promoting MSNJ membership at hospital medical staff meetings.

Report of Executive Director . . .

1. MSNJ Paid Membership . . .

Noted that a total of 5,973 members have paid 1988 dues—slightly ahead of paid memberships last year.

2. Special Assessment . . . Noted that 70 percent of dues-paying members have paid the \$100 special assessment to fund the activities of the Council on Public Relations.

3. MSNJ Financial Statements . . . Approved the financial statements for the periods ending December 31, 1987, and January 31, 1988.

4. SCI Report—Licensing Reform Legislation . . . Noted that licensing reform legislation drafted by Judge Herbert J. Stern was presented to Senator Richard J. Codey; the concept is being prepared in bill form.

5. Reinsurance Association Surcharge . . . Decided that the Secretary is to write a letter to Governor Kean, stating the Society's position on the Reinsurance Association surcharge, and requesting his assistance in arriving at an equitable solution to the situation.

6. AIDS Research Program . . . Approved the Society's cosponsorship of the television program on AIDS research, and authorized a contribution of up to \$10,000 to help underwrite the cost of the production.

7. Medicaid . . . Noted that a rec-

ommendation will be submitted to the Board by the Committee on Medicaid concerning the Garden State Managed Health Care Plan.

UMDNJ . . . Noted the following items from Dr. Bergen's report: the discovery by UMDNJ's research team of the first case of another AIDS virus, HIV-2; proposed investments to meet the "Top 25" challenge by Governor Kean; five-year project to reduce smoking through medical education; and construction of a new research facility for the Center for Molecular Medicine and Immunology.

NJ Hospital Association . . . Noted the following items from Mr. Scibetta's report: the Hospital Rate-Setting Commission approval of the Department of Health recommendation to adjust the labor component of the economic factor; a four-point plan to ease the nursing shortage; scholarship program, educational program, management development program, and salary adjustments; medical waste disposal problems; New Jersey Hospital Association AIDS Task Force; pharmacy bill A-2559 containing provisions for certain reporting requirements for hospitals that own retail pharmacies; and phase-out of the Uncompensated Care Trust Fund Act.

Academy of Medicine of NJ . . .

Noted Doctor Richard C. Reynolds, Executive Vice-President of the Robert Wood Johnson Foundation is the winner of the Edward J. Ill Award and Assemblyman Chuck Hardwick is the recipient of the Citizen's Award; and noted a symposium on AIDS to take place on March 16, 1988.

Impaired Physicians . . .

1. Name Change . . . Approved the following recommendation:

That the Impaired Physicians Program be renamed as the Physicians' Health Program, and that the Committee on Impaired Physicians be renamed as the Committee on Physicians' Health.

2. Drug Abuse Insurance for Members of MSNJ and NJAOPS . . . Referred the following recommendation to the Committee on Membership Services for further study:

That a study be undertaken of the health insurance policies endorsed by the Medi-

cal Society of New Jersey and the New Jersey Association of Osteopathic Surgeons and Physicians to evaluate the practicality of adding coverage for drug abuse.

3. Impaired Physician Without License Needs Insurance for Wife . . .

Noted the case of an impaired physician who voluntarily surrendered his license and lost insurance coverage and membership status in MSNJ; he requested consideration of his needs; the matter to be researched further.

Committee on Long-Range Planning and Development . . .

1. Recommendations: Approved the following three recommendations:

That the Society's policy to require documentation of economic need before members are placed in the dues-exempt category be continued.

That the following dues structure be implemented after age 71, and that eligible members be required to submit a formal request to participate in the dues reduction plan:

- Age 71: Member pays full dues
- Age 72: Member pays 75 percent of dues
- Age 73: Member pays 50 percent of dues
- Age 74: Member pays 25 percent of dues
- Age 75: Dues-exempt/emeritus status

That retired physicians and/or out-of-state physicians, who are not members of the Society but wish to subscribe to certain services (Journal, etc.) shall pay a fee-for-service for these services only.

2. Informational Meetings for the General Membership . . . Approved the following recommendation:

That the President of the Medical Society of New Jersey send letters to the county medical societies, inviting the general membership to attend a specific meeting of the Board of Trustees, to participate in an open forum discussion of issues.

3. Education Program at Annual Meeting . . . Approved the following recommendation:

That the Medical Society of New Jersey proceed with the concept of holding scientific sessions at future Annual Meetings, recognizing that the sessions initially may have to be phased in, depending on the availability of required facilities; and that special emphasis be placed on the blending of major socioeconomic issues and scientific programs.

New Business . . .

1. Blue Shield Payment to Medicare Patients . . . Referred to the

Council on Medical Services complaints that participating physicians who do not accept Medicare fee assignment are fined. Blue Shield sends payment directly to the patient, contrary to their contractual agreement.

2. AMA Leadership Conference . . .

Received a report from Dr. Karl Franzoni on the AMA Leadership Conference, noting the following: Representative Dan Rostenkowski indicated a growing realization by the federal government that the task of providing high-tech health care to an aging population has created a resource shortage problem; and Mr. William Roper was castigated for his premature release of hospital mortality figures. Also, noted Dr. Henry Mineur is a candidate for AMA's Council on Constitution and Bylaws and Dr. Michael Bernstein is being recommended for appointment to the Residency Review Committee for internal medicine; and agreed to place a resolution before the AMA proposing a change of location for the AMA Leadership Conference (usually held in midwinter in Chicago).

3. CME Seminar on Psychiatry in the Soviet Union . . . Noted that Dr. Blakey reported the Council on Mental Health had been asked to endorse a CME seminar on psychiatry in the Soviet Union; he was told that the established position of MSNJ is not to approve or endorse education programs—that is the function of the Academy of Medicine of New Jersey.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.

The eyes of much of the world focused on UMDNJ for two days in January, as researchers at UMDNJ-New Jersey Medical School confirmed the nation's first known case of AIDS caused by the HIV-2 virus.

The fact that the first case wound up at UMDNJ was an accident. The fact that the case was diagnosed correctly was not. The outstanding medical detective work that led to that diagnosis was a direct result of the investment that UMDNJ has made in people and resources in its drive to become one of the premiere health sciences institutions in the country.

The investigative team involved in the discovery was headed by Rajendra Kapila, M.D., and Stanley H.

Weiss, M.D. Dr. Kapila is Director of Infectious Diseases at UMDNJ-University Hospital and is also associate professor of medicine and of preventive medicine and community health at the medical school. Dr. Weiss is a former National Cancer Institute investigator involved in some of the nation's most important AIDS findings of the past few years. He is an assistant professor of medicine and of preventive medicine and community health at the medical school.

The doctors reported that the case involved a visitor from West Africa who was admitted to University Hospital with neurological symptoms. They emphasized that the case appeared to be isolated and that there was no evidence of any potential spread of the new virus to others in this country.

The investigation began when the patient was found to have infections of the central nervous system indicative of AIDS. However, the standard antibody test performed for HIV-1 had ambiguous results. Since the patient came from West Africa, where the HIV-2 virus was originally documented, the physicians contacted the Centers for Disease Control and arranged for further blood testing. The subsequent test results were found by an out-of-state laboratory to be "strongly positive" for HIV-2.

The means of transmission for the virus appear to be similar to HIV-1, which means the same precautions would apply. The physicians are optimistic that surveillance for this virus will be easier than for HIV-1 because the blood test for HIV-2 already is available. Also, they noted that out of more than 20,000 blood samples tested for the virus in this country among individuals at high risk for HIV-1, not one has been confirmed to have HIV-2 antibodies.

Aside from Drs. Kapila and Weiss, the investigative team at New Jersey Medical School included Jennifer Michaels, M.D., of the department of neurosciences; Joseph Lombardo, M.D., and Leroy Sharer, M.D., of the department of pathology; Maria Tayyarah, M.D., of the department of preventive medicine and community health; Joan Leonard, M.D., Anthony Mangia, M.D., Patricia Kloser, M.D., and S. Sathe, M.D., all of the department of medicine; and James Oleske, M.D., and Thomas Denny,

from the division of allergy, immunology, and infectious diseases.

I am proud of the interdisciplinary effort that went into the discovery and understanding of this complicated virus—an effort that reflects well on UMDNJ's continuous drive for excellence. I feel certain that when the epitaph of the AIDS epidemic is finally written, the University of Medicine and Dentistry of New Jersey, already recognized nationally for research into the disease, will figure prominently.

AMNJ Report

Anthony B. Minnefor, M.D.

The Board of Trustees of the Academy of Medicine of New Jersey has named the 1988 recipients of the Awards to be presented at the Annual Awards Dinner on Wednesday, May 25, 1988, at the Chanticleer in Short Hills.

Richard C. Reynolds, M.D., will receive the Edward J. Ill Award "presented annually to that physician of New Jersey who merits recognition by the Academy for distinguished service as a leader in the medical

profession." Recent recipients have included Drs. James Todd, Leon G. Smith, Arthur Krosnick, Alfred Alessi, Stanley Bergen, Palma Formica, and Paul Hirsch. Dr. Reynolds is best known for his many contributions to New Jersey medicine as Dean of UMDNJ-Robert Wood Johnson Medical School and as UMDNJ Senior Vice-President for Academic Affairs. The rapid development of UMDNJ and, in particular, the growth of Robert Wood Johnson Medical School in large part can be attributed to Dr. Reynolds' efforts. He also has found the time to participate in the activities of organized medicine and currently is serving as Vice-President of the Middlesex County Medical Society.

The Academy's Citizen's Award is "presented annually to that citizen or group of citizens of New Jersey who merit recognition by the Academy for distinguished service in the interest of the health and welfare of the community at large." The 1988 Citizen's Award has been granted to Chuck Hardwick. Mr. Hardwick, currently the Speaker of the New Jersey Assembly, has given tirelessly of himself in matters of assuring ap-

propriate health care delivery for all citizens. Included in his many efforts is the sponsorship of malpractice reform legislation.

Another important aspect of our 1988 dinner will be the election of Dr. James S. Todd to Honorary Fellowship. Dr. Todd, who presently is Senior Deputy Executive Vice-President of the American Medical Association, was the recipient of the Edward J. Ill Award in 1980. Dr. Todd will become the sixth individual in the history of the Academy to receive this honor which may be bestowed on any physician or scientist of exceptional eminence.

The Academy is pleased to announce that we have agreed to assume the office management functions for the New Jersey Association of Electromyography and Electrodiagnosis. The organization consists of approximately 120 physician members who either are physiatrists or neurologists. Dr. Melvin Goldberg of Clifton is the current President and Dr. Champa Bid of Saddle Brook is Secretary/Treasurer.

The 1988 schedule for the New Jersey Physicians Golf Association

NEW JERSEY MEDICINE

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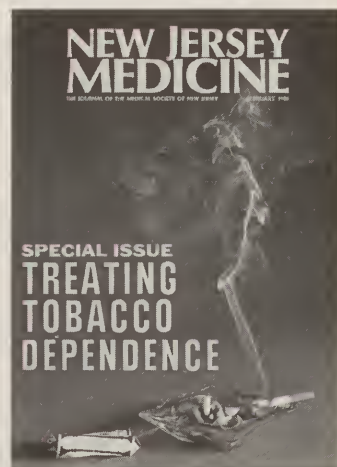
NEW JERSEY MEDICINE

The Journal of the Medical Society of New Jersey

Two Princess Road

Lawrenceville, NJ 08648

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is almost complete and has been mailed to the membership. A number of outstanding courses is on the tour including the famous Baltusrol Country Club in August. Further information on membership in the organization is available.

New Members

The Medical Society of New Jersey would like to welcome the following new members:

Atlantic County

Laura J. Bonaker, M.D., Northfield
Robert L. Courtney, D.O.,

Mays Landing

Albert C. Dearden, M.D., Northfield
Gary L. Feinberg, M.D., Somers Point
Richard K. Gadon, M.D.,

Hammonton

Robert F. Oldt, M.D., Ocean City

Gary A. Rosman, M.D., Ventnor

James N. Semertzides, M.D.,

Atlantic City

Bergen County

Russell S. Asnes, M.D., Tenaflly
Thomas Golin, M.D., Woodcliff Lake
Fletcher J. Johnson, Jr., M.D.,

Englewood

Peter F. Migel, M.D., Tenaflly

Richard A. Norden, M.D., Ridgewood

Joel I. Rakow, M.D., River Edge

Paul C. Rodigas, M.D., Hackensack

Michael P. Scherl, M.D., Westwood

Ashok K. Sharma, M.D.,

Midland Park

Lynn B. Sugarman, M.D., Tenaflly

William R. Ventura, M.D., Hillsdale

Howard B. Weizman, M.D.,

Midland Park

David H. Wisotsky, M.D., Tenaflly

Burlington County

Mary F. Campagnolo, M.D.,

Westhampton

Sander M.Z. Cohen, M.D.,

Moorestown

Lee M. deLacy, M.D., Willingboro

Frank A. Grill, D.O., Medford

Steven W. Klier, M.D., Moorestown

Margaret M. LaManna, M.D.,

Browns Mills

Irene C. Magran, M.D., Mt. Laurel

Michael H. Minoff, M.D., Willingboro

Stanley S. Paist, III, M.D., Medford

Dante A. Ragasa, M.D., Mount Holly

Kathleen L. Ryan, M.D.,

Mount Laurel

Yeva G. Rubinstein, M.D., Mount

Laurel

R. Blair Summersgill, M.D.,

Moorestown

Ngoc (Daniel) B. Tran, M.D.,

Willingboro

Joel S. Yudin, D.O., Mount Laurel

Camden County

Joel P. Chack, D.O., Haddonfield

William E. Johnston, M.D., Camden

Walter E. Klodnicki, M.D., Cherry Hill

Ralph C. Lanciano, Jr., D.O.,

Pennsauken

Janet L. Mahan, M.D., Maple Shade

Sally W. Pullman-Mooar, M.D.,

Cherry Hill

Bennett K. Schwartz, M.D., Voorhees

Cumberland County

Paul Peterson, III, D.O., Vineland

Joseph D. Wachspress, M.D.,

Vineland

Essex County

Donna E.B. Asendio, M.D.,

South Orange

Kalavathi Ayyagari, M.D., Irvington

Kamalakar Rao Ayyagari, M.D.,

Irvington

James E. Haberman, M.D., Newark

James A. Heimann, M.D., Roseland

Sam T. Locatelli, M.D., Maplewood

Robert D. Orringer, M.D., Millburn

Janis A. Pastena, M.D., Newark

Matthew R. Ponzio, M.D., Montclair

Robert J. Sipzner, M.D., Livingston

Hudson County

Gilberto F. Gastell, M.D., Union City

Devarajan P. Iyengar, M.D., Bayonne

Richard S. Laskey, M.D., Hoboken

Emiliana P. Sandoval, M.D.,

Secaucus

Mercer County

Pei-Jon Chen, M.D., Princeton

Kim H. Millar, M.D., Princeton

John R. Morgan, M.D.,

Doylestown, PA

Steven C. Nadler, M.D., Plainsboro

Lawrence M. Ratner, M.D., Trenton

Michael G. Stebbins, M.D., Princeton

Theodore R. Swartz, M.D.,

Mercerville

Ethan A. Tarasov, M.D., Trenton

Randy S. Tartacoff, M.D.,

Lawrenceville

Middlesex County

Leonard Bodner, M.D.,

East Brunswick

Steven R. DelMaestro, M.D.,

Piscataway

Jozsef S. Dull, M.D., Perth Amboy

Richard S. Feinstein, M.D.,

East Brunswick

Howard M. Kipen, M.D., Piscataway

Reuben S. Mezrich, M.D.,

New Brunswick

Sandra W. Moss, M.D., Metuchen

Samuel A. Pasquale, M.D.,

New Brunswick

Anil N. Patel, M.D., Avenel

Mark J. Pressman, M.D., Edison

Carol T. Sarokhan, M.D.,

Basking Ridge

Monmouth County

Samir Al-Kabbani, M.D.,

Neptune City

Joseph P. Cleaver, M.D., Deal

Joseph W. DiTuro, M.D., Eatontown

Eric M. Kardon, M.D., Ocean Grove

Gary M. Pess, M.D., Oakhurst

Janice M. Siciliano, D.O., Interlaken

Robert M. Thompson, M.D.,

Neptune City

Charles A. Weber, M.D.,

Wall Township

Morris County

Marc A. Cohen, M.D., Madison

Kenneth Cubelli, M.D., Denville

Gary S. Friedman, M.D., Springfield

Fern Gotfried, M.D., Short Hills

Kathy R. Kerr, M.D., Piscataway

Jeffrey K. Miller, M.D., Madison

Abraham H. Rosenzweig, M.D., Dover

Barry S. Reed, M.D., Montclair

Eugene R. Ross, M.D., Succasunna

Andreas D. Rotsides, M.D.,

Convent Station

Jeffrey M. Wolk, M.D., Denville

Ocean County

Patrick J. Connolly, M.D.,

Toms River

Charles P. Fernicola, M.D.,

Manahawkin

James N. Suddeth, M.D.,

Beach Haven

Passaic County

Veena Agarwal, M.D., Paterson

Ellenjeane Albanese, M.D., Paterson

Lawrence Ambrose, M.D., Totowa

Joseph M. Masessa, M.D., Milford

Lorelle N. Michelson, M.D., Clifton

Manuel Uribe, M.D., Paterson

Salem County

Ricardo R. Sion, M.D., Salem

Sussex County

Randall C. Cronin, Jr., M.D., Newton

Rakesh K. Garg, M.D., Newton

Robert A. Herbert, M.D., Newton

James L. Scales, Jr., M.D., Sparta

Robert C. Weinschenk, M.D., Sparta

Union County

Douglas S. Ashinsky, M.D., Westfield

Howard J. Buchbinder, M.D., Edison

Leon F. Kukla, M.D., Colonia

Marvin A. Lipsky, M.D., West Orange

Rhona A. Magaril, M.D., Westfield

Michael L. Margolin, M.D., Elizabeth

David L. Romano, M.D., Plainfield

Warren County

Tomas F. Lichauco, M.D.,

Allentown, PA

Jacqueline E. Zuckerbrod, D.O.,

Annandale

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY—Jerry Michael Shier, M.D., 11546 February Cir., Apt. 202, Silver Spring, MD 20904. UMDNJ 1982. Also, clinical immunology. Board eligible. Board certified (PED). Group, partnership, solo. Available July 1988.

ANESTHESIOLOGY—Daniel O'Brien, M.D., 12 Beech Dr., Brunswick, ME 04011. Liege (Belgium) 1975. Board certified. Group, partnership, solo. Available.

Steven H. Ressler, M.D., 424 North Midland Ave., Saddlebrook, NJ 07662. Guadalajara 1982. Board eligible. Group or fee-for-service. Available July 1988.

CARDIOLOGY—Richard Don Diego, M.D., 6020 Danny Kaye, #906, San Antonio, TX 78240. Central Caribbean (Puerto Rico) 1981. Also, internal medicine. Board eligible. Group or partnership. Available July 1988.

Donald G. Rubenstein, M.D., 1037 3rd St., #303, Santa Monica, CA 90403. Louisiana 1980. Board eligible. Group or partnership. Available August 1988.

Govindaraju Subramani, M.D., 4250 N. Marine Dr., Apt. 506, Chicago, IL 60613. Wisconsin 1987. Board eligible. Partnership or group. Available.

ENDOCRINOLOGY—Gerald B. Miele, M.D., 110 Fleet Pl., Mineola, NY 11501. Rush 1983. Also, internal medicine. Board eligible. Partnership, group, solo. Available July 1988.

FAMILY MEDICINE—Roy Berkowitz-Shelton, M.D., 132 Grove Pk., Ft. Dix, NJ 08640. Georgetown 1981. Board certified. Partnership. Available.

Serge I. Kaftal, M.D., 30 South Auten Ave., Somerville, NJ 08876. Lodz (Poland) 1980. Board eligible. Solo, partnership, group. Available November 1988.

Chava Zimmerman, M.D., 127F Amberly Dr., Manalapan, NJ 07726. Wayne State 1978. Board certified. Group or HMO. Available July 1988.

GASTROENTEROLOGY—Anil Agarwal, M.D., 18 Maltese Dr., Fair Lawn, NJ 07410. LLRM Medical (India) 1979. Also, internal medicine. Board eligible. Board certified (IM). Available July 1988.

David Rosenbock, M.D., 5 Riggs Pl., West Orange, NJ 07052. UMDNJ. Board eligible. Board certified (IM). Group, partnership, solo. Available July 1988.

INTERNAL MEDICINE—Anil Agarwal, M.D., 18 Maltese Dr., Fair Lawn, NJ 07410. LLRM Medical 1979. Also, gastroenterology. Board certified. Available July 1988.

Paul R. Axelrad, M.D., 666 Ninth St., Lakewood, NJ 08701. St. George's University 1985. Methodist Hospital. Board eligible. Group or partnership. Available July 1988.

Glenn A. Dubov, M.D., 75-36 Bell Blvd., Apt. 2A, Bayside, NY 11364. Chicago 1983. Board certified. Group or partnership. Available July 1988.

Marc Hanfling, D.O., 26 Glen Lane, Cherry Hill, NJ 08002. New York College 1981. Also, cardiology. Board certified. Board eligible (CARD). Group, partnership, solo. Available.

Peter Kuzmick, D.O., 62 Diamond Ave., Fort Rucker, AL 36362. Kansas City College 1980. Board certified. Group or partnership. Available July 1988.

Gerald B. Miele, M.D., 110 Fleet Pl., Mineola, NY 11501. Rush 1983. Also, endocrinology. Board eligible. Partnership, group, solo. Available July 1988.

Edward C. Phillips, M.D., 24 Walnut St., Summit, NJ 07901. Downstate 1984. Board eligible. Group, partnership, solo. Available July 1988.

Joseph T. Wayne, M.D., 106 Elmwood Dr., Prudenville, MI 48651. SUNY-Buffalo 1982. Board eligible. Board certified (PED). Also, pediatrics. Group,

partnership, academic. Available October 1988.

NEPHROLOGY—Glenn A. Dubov, M.D., 75-36 Bell Blvd., Bayside, NY 11364. Chicago 1983. Also, internal medicine. Board certified (IM). Group or partnership. Available July 1988.

PEDIATRICS—Joseph T. Wayne, M.D., 106 Elmwood Dr., Prudenville, MI 48651. SUNY-Buffalo 1982. Also, internal medicine. Board certified. Board eligible (IM). Group, partnership, academic.

Linda York-Chance, M.D., 435 East 70th St., New York, NY 10021. Connecticut 1985. Board eligible. Clinic or emergency room. Available July 1988.

PULMONARY—Martin J. Greenberg, M.D., 76 Church St., Montclair, NJ 07042. Ross 1983. Board eligible. Partnership or group. Available July 1988.

SURGERY—James H. Frost, M.D., 655 W. Irving Pk. Rd., Apt. 4306, Chicago, IL 60613. Guadalajara; Mt. Sinai Fifth Pathway 1983. Board eligible. Group or partnership. Available July 1988.

Robert M. O'Brien, M.D., 182 Estates Dr., Piedmont, CA 94611. Vermont 1958. Also, noncardiac thoracic surgery. Board certified. Group, partnership, solo, in southern New Jersey only. Available.

Ninth Annual Morris Saffron Lecture

May 11, 1988
1 P.M.

Speaker:
Dr. Regina Markell Morantz-Sanchez
*"To Humanize Not Feminize: The
Future of the Woman Doctor
in the United States"*

Academy of Medicine of New Jersey
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CARDIOLOGY UPDATE ...

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current status of Clinical Cardiology ...

WEDNESDAY
MAY 4, 1988
3:00 to 5:00 PM

SYSTEMIC HYPERTENSION

MODERATOR: BERNARD L. SEGAL, M.D.

3:00-3:20	Diagnosis and management of essential vascular hypertension	Robert Stote, M.D.
3:20-3:40	Diagnosis and management of renal vascular hypertension	Albert Brest, M.D.
3:40-4:00	Assessment of left ventricular function and mass	Ami S. Iskandrian, M.D.
4:00-4:30	Case presentations	Steven Nierenberg, M.D.
4:30-5:00	Panel discussion	Morton Shragar, M.D., Charles A. Syms, M.D.

- No Registration Fee
- No Advance Registration Required
- CME Credits*

* * Refreshments Served Following Each Session * *

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The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization for further information.

CARDIOLOGY

May

- 9 **Cardiac Rehabilitation**
7-8 P.M.—Wallkill Valley General Hospital, Sussex (AMNJ)
- 26 **Anti-Arrhythmic Therapy**
3-4 P.M.—Ancora Psychiatric Hospital, Hammondon (AMNJ)
- 26 **Pathophysiology and Management of Acute Heart Failure**
11 A.M.—St. Joseph's Hospital and Medical Center, Paterson (St. Joseph's Hospital and Medical Center)

June

- 1 **Anti-Arrhythmic Therapy/Clinical Arrhythmia**
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic (AMNJ)
- 1 **Streptokinase and Percutaneous Transluminal Coronary Angioplasty**
10:30-11:30 A.M.—Christ Hospital, Jersey City (AMNJ)
- 1 **Advanced Cardiac Life Support**
- 8 6 P.M.—Freehold Area Hospital, Freehold (Freehold Area Hospital)
- 16 **Ventricular Arrhythmias . . . When To Treat**
11 A.M.—St. Joseph's Hospital and Medical Center, Paterson (St. Joseph's Hospital and Medical Center)

DERMATOLOGY

May

- 10 **Annual Dinner, Dermatological Society of New Jersey**
6:30 P.M.—Chanticleer, Short Hills (Dermatological Society of NJ)
- 18 **Dermatology Conferences**
6-9 P.M.—Rutgers Community Health Plan, 57 U.S. Highway 1, New Brunswick (UMDNJ)

June

- 2 **Common Dermatoses**
2:30-3:30 P.M.—New Lisbon Developmental Center, New Lisbon (AMNJ)

MEDICINE

April

- 18- **HIV in Children**
- 19 Sheraton Meadowlands Hotel, East Rutherford (New Jersey Department of Health)

May

- 2 **Rheumatology Staff Conference**
5:30-7 P.M.—Robert Wood Johnson Medical School, MEB-393, New Brunswick (UMDNJ)
- 4 **Computers in Medicine**
10:30-11:30 A.M.—Christ Hospital, Jersey City (AMNJ)
- 4 **New Approaches to Gastrointestinal Bleeding**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth (Alexian Brothers Hospital)
- 7 **Endocrine Series**
11:30 A.M.-1 P.M.—VA Medical Center, East Orange (AMNJ)
- 10 **Chronic Pain Management and Issues Related to Iatrogenic Addiction**
12 noon-1 P.M.—Hospital Center at Orange (AMNJ)

11 Medical Grand Rounds

- 18 10 A.M.—St. Mary Hospital, Hoboken (St. Mary Hospital)

11 New Treatments in Cerebrovascular Disease

- 1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove (AMNJ)

11 Role of Operative Cholangiography in Biliary Tract Surgery

- 10:30-11:30 A.M.—Saint Mary's Hospital, Passaic (AMNJ)

11 Drug-Induced Lung Disease

- 8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth (Alexian Brothers Hospital)

11 Annual Morris Saffron Lecture

- 10 A.M.-2 P.M.—Medical Society of New Jersey, Lawrenceville (Medical History Society of New Jersey)

12 Potassium Loss

- 12 noon-1 P.M.—Community Memorial Hospital, Toms River (Community Memorial Hospital)

17

The Treatment of Glomerulonephritis

- 4-5 P.M.—Robert Wood Johnson Medical School, MEB, New Brunswick (UMDNJ)

19

Fluid and Electrolyte Imbalance

- 1:30-2:30 P.M.—Vineland Developmental Center and Hospital (AMNJ)

19

Clinical Issues in Human Sexuality

- 5-6:30 P.M.—Somerset Medical Center, Fuld Auditorium, Somerville (Somerset Medical Center)

26

Visiting Professor Program

- 1:30-2:30 P.M.—Saint Barnabas Medical Center, Livingston (Saint Barnabas Medical Center)

30

Caring for the Patient on a Ventilator

- 1:30-2:30 P.M.—Health Maintenance Organization, New Brunswick (Rutgers Community Health Plan)

June

6

Rheumatology Staff Conference

- 5:30-7 P.M.—Robert Wood Johnson Medical School, MEB-393, New Brunswick (UMDNJ)

7

Hirsutism

- 7-8 P.M.—West Hudson Hospital, Kearny (West Hudson Hospital)

8

New Treatments in Cerebrovascular Diseases

- 10:30-11:30 A.M.—Saint Mary's Hospital, Passaic (AMNJ)

8

Medical Grand Rounds

15

- 10 A.M.—St. Mary Hospital,

22

- Hoboken (St. Mary Hospital)

8

Joint Meeting: NJ Society for Gastrointestinal Endoscopy and NJ Gastroenterological Society

- 3 P.M.—The Manor, West Orange (NJ Society of Gastrointestinal Endoscopy and NJ Gastroenterological Society)

14

Myasthenia Gravis

- 12 noon-1 P.M.—Hospital Center at Orange (AMNJ)

15

Proper Use of Endoscopy

- 10:30-11:30 A.M.—Saint Mary's Hospital, Passaic (AMNJ)

16

Entrepreneurial Medicine: Does It Challenge Traditional Medicine?

- 5-6:30 P.M.—Fuld Auditorium, Somerset Medical Center, Somerville (Somerset Medical Center)

17

Infectious Diseases—AIDS, Hepatitis, New Cephalosporins

- 10:30-11:30 A.M.—Woodbridge Developmental Center, Woodbridge (AMNJ)

21

Regional Nephrology Conference Series

- 4-5 P.M.—Robert Wood Johnson Medical School, MEB, New Brunswick (UMDNJ)

June 6-10, 1988
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**The Academy of Medicine of New Jersey
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and Related Disorders
and the
Somerset Medical Center
present**

Alzheimer's Disease Update—1988

on
Wednesday, May 18, 1988
9:30 a.m.-4:30 p.m.

at
Somerset Medical Center
Somerville, New Jersey

OVERVIEW

This conference is directed at physicians and other health care providers who wish to expand their knowledge of Alzheimer's Disease and other dementing illness. It will build on the knowledge gained from the previous conferences (ALZHEIMER'S DISEASE UPDATE—1987) by dealing with current information regarding this group of illnesses. However, participants need not have attended the conference in 1987 to profit from the material to be presented. The course faculty represents individuals with first-hand knowledge of the clinical, psychological and ethical issues involved in the diagnosis and management of individuals with dementing syndromes.

OBJECTIVE

*Participants will be able to integrate new developments in geriatrics with their current knowledge to manage their elderly patients more effectively.

FRANK C. SNOPE, M.D.
 Symposium Chairman
 Professor, Department of Family Medicine
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- 30 New Treatments in Cerebrovascular Disease**
2-3 P.M.—John E. Runnells Hospital of Union County, Berkeley Heights (AMNJ)

NEUROLOGY

May

- 11 New Treatments in Cerebrovascular Disease**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove (AMNJ)

June

- 8 New Treatments in Cerebrovascular Disease**
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic (AMNJ)
- 14 Myasthenia Gravis**
12 noon-1 P.M.—Hospital Center at Orange (AMNJ)
- 30 New Treatments in Cerebrovascular Disease**
2-3 P.M.—John E. Runnells Hospital of Union County, Berkeley Heights (AMNJ)

OBSTETRICS/GYNECOLOGY

May

- 4 Cancer of the Cervix**
10:30-11:30 P.M.—Saint Mary's Hospital, Passaic (AMNJ)
- 18 Laparoscopy and Colposcopy**
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic (AMNJ)
- 20- Birth Injuries and the Law**
Resorts International Hotel, Atlantic City (UMDNJ)
- 22 Vaginal Discharge and P.I.D.**
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic (AMNJ)
- 26 Perinatal Conference**
7-9 P.M.—Newcomb Medical Center, Vineland (Newcomb Medical Center)

June

- 10- Annual Meeting, New Jersey**
- 11 Obstetrical and Gynecology Society**
The Hyatt Regency, Inner Harbor, Baltimore (New Jersey Obstetrical and Gynecology Society)
- 23 Perinatal Conference**
7-9 P.M.—Newcomb Medical Center, Vineland (Newcomb Medical Center)

ONCOLOGY

May

- 2 Hematology/Oncology Conference**
12 noon-1 P.M.—Robert Wood Johnson Medical School, MEB-108A, New Brunswick (UMDNJ)
- 5 Tumor Board Conferences**
12 9-11 A.M.—Irvington General Hospital (Irvington General Hospital)

- 6 Cancer Research Colloquium**
12 noon-1:15 P.M.—New Jersey Medical School, MSB, G-506B, Newark (UMDNJ)
- 11 Scientific Dinner Meeting**
6:30-9:30 P.M.—The Manor, West Orange (AMNJ)
- 26 Tumor Board Conferences**
12 noon—Newcomb Medical Center, Vineland (Newcomb Medical Center)

June

- 2 Cancer Research Colloquium**
12 noon-1:15 P.M.—New Jersey Medical School, MSB, G-506B, Newark (UMDNJ)
- 16 Hematology/Oncology Conference**
12 noon-1 P.M.—Robert Wood Johnson Medical School, MEB-108A, New Brunswick (UMDNJ)
- 13 Colon-Rectal Cancer**
7-8 P.M.—Wallkill Valley General Hospital, Sussex (AMNJ)
- 23 Tumor Board Conferences**
12 noon—Newcomb Medical Center, Vineland (Newcomb Medical Center)

ORTHOPEDICS

May

- 5 Orthopaedic Grand Rounds**
7:30-9 P.M.—Robert Wood Johnson Medical School, New Brunswick (UMDNJ)
- 19 Orthopaedic Grand Rounds**
7:30-9 P.M.—Robert Wood Johnson Medical School, New Brunswick (UMDNJ)
- 20 Clinical Examination of the Back, Knee, and the Hip**
8-9 A.M.—West Hudson Hospital, Kearny (West Hudson Hospital)

PATHOLOGY

May

- 3 Renal Pathology Conference**
12 noon-1 P.M.—Robert Wood Johnson Medical School, New Brunswick (UMDNJ)
- 13- Eastern Regional Pathology Conference**
Resorts International Hotel and Casino, Atlantic City (New Jersey Society of Pathologists)
- 19 Hematopathology Conference**
4-5 P.M.—St. Peter's Medical Center, New Brunswick (Muhlenberg Medical Center)

June

- 7 Renal Pathology Conference**
12 noon-1 P.M.—Robert Wood Johnson Medical School, New Brunswick (UMDNJ)
- 16 Hematopathology Conference**
4-5 P.M.—Robert Wood Johnson

Medical School, New Brunswick (Muhlenberg Medical Center)

PEDIATRICS

May

- 3 Case Conferences**
8-9 A.M.—Robert Wood Johnson Medical School, MEB-108A, New Brunswick (UMDNJ)
- 5 Pediatric Grand Rounds**
8:30-9:30 A.M.—Robert Wood Johnson Medical School, MEB-102, New Brunswick (UMDNJ)
- 6 Advances in Pediatrics**
9:30-10:30 A.M.—New Jersey Medical School, MSB, B-610, Newark (UMDNJ)
- 13 New Exanthems of Childhood**
8 A.M.-12 noon—Overlook Hospital, Summit (Overlook Hospital)

June

- 3 Advances in Pediatrics**
9:30-10:30 A.M.—New Jersey Medical School, MSB, B-610, Newark (UMDNJ)
- 7 Case Conferences**
8-9 A.M.—Robert Wood Johnson Medical School, MEB-108A, New Brunswick (UMDNJ)
- 9 Pediatric Grand Rounds**
8:30-9:30 P.M.—Robert Wood Johnson Medical School, MEB-102, New Brunswick (UMDNJ)
- 10 Growing Up in the 1990s**
8 A.M.-12 noon—Overlook Hospital, Summit (Overlook Hospital)
- 14 New Concepts in the Treatment of Seizures and Epilepsy**
9:30-10:30 A.M.—Newark Beth Israel Medical Center, Newark (Newark Beth Israel Medical Center)

PSYCHIATRY

May

- 2 Postdivorce Stress Disorder**
8:15 P.M.—326 Park Street, Montclair (Essex Psychiatric Seminars)
- 3 Developmental Disabilities**
10-11 A.M.—Green Brook Regional Center (AMNJ)
- 5 Case Seminars**
8-10 P.M.—312 Harding Drive, South Orange (Advanced Psychiatric Study Group)
- 5 Obsessive-Compulsive Behavior**
12 noon-1 P.M.—Carrier Foundation, Belle Mead (Carrier Foundation)
- 6 Update on Lithium**
1:15-3:30 P.M.—Marlboro Psychiatric Hospital, Marlboro (Marlboro Psychiatric Hospital)
- 13 Psychiatric Lecture Series**
1:30-2:30 P.M.—Trenton Psychiatric

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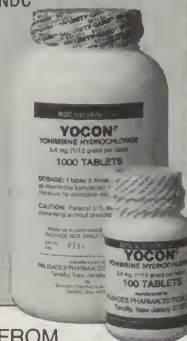
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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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18 Treatment of Insomnia
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth
(Alexian Brothers Hospital)

19 Scientific Meeting
Saint Barnabas Medical Center, Livingston
(NJ Psychoanalytic Society)

19 Clinical Issues in Human Sexuality—An Update on Drugs, Diseases, and Devices
5-6:30 P.M.—Fuld Auditorium, Somerset Medical Center, Somerville
(Somerset Medical Center)

19 Audiovideo Technique in Clinical Practice
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

25 Depression in the Elderly
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth
(Alexian Brothers Hospital)

25 Obsessive-Compulsive Disorders
9 A.M.-5 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

26 Seasonal Depression
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

June

2 Case Seminars

16 8-10 P.M.—312 Harding Drive, South Orange
(Advanced Psychiatric Study Group)

2 Cold Cruelty and Loving Humanity of Medicine
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

3 Psychiatric Lecture Series

10 1:30-2:30 P.M.—Trenton Psychiatric Hospital
(Trenton Psychiatric Hospital)

6 Psychiatric Complications of Multiple Sclerosis
8:15-10:15 P.M.—325 Park Avenue, Montclair
(Essex Psychiatric Seminars)

9 Stress Management and Creative Juggling for Clinicians
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

16 Scientific Meeting
Saint Barnabas Medical Center, Livingston
(NJ Psychoanalytic Society)

16 This Is Me—Art Therapy with Anorexics
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

22 Parenting/Children of Divorce
9 A.M.-5 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

23 Medical and Psychiatric Aspects of Drug and Alcohol Abuse
3-4 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

30 Caring for the Caretakers: Treating Impaired Professionals
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

RADIOLOGY

May

3 Renal Tumors of the Newborn
8:30-9:30 A.M.—Newark Beth Israel Medical Center, Newark
(Newark Beth Israel Medical Center)

18 Dinner Meeting
6:30-9:30 P.M.—The Manor, West Orange
(Radiation Oncology Section-AMNJ)

19 Scientific Meeting
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(AMNJ)

SURGERY AND SURGICAL SPECIALTIES

May

2 Surgical Grand Rounds

9 4:30-5:30 P.M.—New Jersey Medical School, MSB, B-610, Newark
(UMDNJ)

23 Surgical Treatment of

7 Cardiothoracic Diseases
10-11:30 A.M.—New Jersey Medical School, MSB, G-506, Newark
(UMDNJ)

7 Morbidity and Mortality

14 Conference

21 8:30-10 A.M.—New Jersey Medical School, MSB, B-610, Newark
(UMDNJ)

28 Management of Abdominal Emergencies
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic
(AMNJ)

11 Role of Operative Cholangiography in Biliary Tract Surgery
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic
(AMNJ)

16 Surgical Conferences and Experience in the Soviet Union and Budapest
8-9 A.M.—West Hudson Hospital, Kearny
(West Hudson Hospital)

18 Surgical Conference
11 A.M.—St. Mary Hospital, Hoboken
(St. Mary Hospital)

19-22 Annual Meeting, Eastern Vascular Society
The Willard Hotel, Washington, D.C.
(Eastern Vascular Society)

24 AIDS Update
8-10 P.M.—Englewood Club, 115 E. Palisade Avenue, Englewood
(Englewood Surgical Society)

June

4 Surgical Treatment of Cardiothoracic Diseases
10-11:30 A.M.—New Jersey Medical School, MSB, G-506, Newark
(UMDNJ)

6 Morbidity and Mortality

13 Conference

20 8:30-10 A.M.—New Jersey Medical School, MSB, B-610, Newark
(UMDNJ)

27 Surgical Conference
11 A.M.—St. Mary Hospital, Hoboken
(St. Mary Hospital)

UROLOGY

May

1 Urology Grand Rounds
Robert Wood Johnson Medical School, MEB-108B, New Brunswick
(UMDNJ)

4 William P. Burpeau Award Dinner
6:30-9:30 P.M.—The Manor, West Orange
(Urology Society of New Jersey and AMNJ)

25 Clinical Cases Presentation
6:30-7 P.M.—Robert Wood Johnson Medical School, New Brunswick
(UMDNJ)

June

1 Urology Grand Rounds
Robert Wood Johnson Medical School, MEB-108B, New Brunswick
(UMDNJ)

22 Clinical Cases Presentation
6:30-7 P.M.—Robert Wood Johnson Medical School, New Brunswick
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From Hippocrates to Virchow, Reflections on Human Disease; The Ischemic Leg; Manual for Eye Examination and Diagnosis; 1987 Year Book of Family Practice; Office Gynecology; Primary Care of the Newborn

From Hippocrates to Virchow, Reflections on Human Disease

James M. Byers, M.D. Chicago, IL, ASCF Press, 1987.

The term "Renaissance man" has been bandied around so loosely in recent years that it has lost much of its significance, yet the author of the present work seems almost worthy of the designation.

A pathologist who avows interest in archaeology, nature photography, and exhibition horsemanship, Dr. Byers still has found time to write a book which has the laudable purpose of luring the average physician back to a reappraisal of his long neglected heritage. In order to accomplish this, Dr. Byers has selected from the writings of the great thinkers pertinent passages relating to medical practice and thought, which he then proceeds to comment upon and show their relevance to our times. Thus, in discussing the *Prognosis* of Hippocrates (as did Maurus of Salerno), he points out the importance of explaining candidly to the patient and his family the dangers inherent in the disease in order to promote trust between

the sick man and his doctor and avoid later lawsuits. Among the other luminaries whose thoughts are examined are Plato, Aristotle, Thucydides, Avicenna, and Maimonides among the older men; Chaucer, Aquinas, Montaigne, and Harvey among the more recent.

Despite its rather outré oblong appearance, this is a most stimulating book which should give pleasure to all thinking physicians. It is well illustrated, but has two minor faults: it has been indexed to a ludicrous excess and the editor apparently never learned the value of the abbreviation *Ibid*.

Morris H. Saffron, M.D.

The Ischemic Leg

Richard F. Kempczinski, M.D. Chicago, IL, Year Book Medical Publishers, Inc., 1985. Pp. 587.

This comprehensive volume is written in a unified fashion despite the participation of 55 recognized and experienced contributors. Amazingly, little repetition is noted and the multiauthors styles blend comfortably lending themselves to easy reading. Illustrations are clear and compliment the topics appropriately. The bold typeface minimizes eye strain.

The book is separated into five sections beginning with the historical developments of lower extremity revascularization, the natural history of atherosclerotic ischemia as well as other causes of ischemia, and the impact of diabetes and related disorders. An elaborate presentation of noninvasive and invasive diagnostic modalities follows. A section on nonoperative management precedes the largest section of the book which details the various surgical approaches, their indications, and short- and long-term results. The chapters describing "on the shelf" grafts as opposed to autogenous tissue serve as excellent guidelines to current graft utilization. The final section focuses on amputations, indications and preferences, technical details, and rehabilitation. The chapter on amputations as an alternate form of treatment for restoring a bipedal gait deserves special attention.

There are few omissions that warrant flagging. Compliments are forthcoming to the editor and contributors for their thoroughness. Supplemental references were perti-

nent and well chosen. *The Ischemic Leg*, an excellent and current compilation, is recommended to surgeons at all levels of vascular training and experience. It rightfully deserves a place in your library.

Joseph Alpert, M.D.

Manual for Eye Examination and Diagnosis

Mark W. Leitman, M.D. Oradell, NJ, Medical Economics, 1988.

Dr. Leitman has written a well-organized manual of ophthalmic examination and diagnosis. This manual is aimed at the medical student, and is a very useful adjunct for the medical or surgical intern desiring a concise introduction to the ophthalmic examination.

The manual is organized and presented in the basic order of the ophthalmic examination. Aside from the few drawings in the back of the book, all of the illustrations are black-and-white drawings. For the most part, the drawings are quite well done and serve to point out the condition being explained. The text could benefit from some photographs in color, though this would increase the cost of the book significantly.

The text begins with the medical history, listing and explaining common chief complaints. Dr. Leitman importantly draws attention to the relationships of ophthalmic to systemic diseases. Visual acuity is explained in the next chapter with a very brief introduction to optics as related to the ametropias. There also is a short section of this chapter mentioning the corrections of the ametropias, including spectacles, contact lenses, and radial keratotomy. This section is a little too brief and would be better if expanded slightly.

The chapter on neuro-ophthalmology nicely reviews the nerve innervations, visual pathways, pupillary abnormalities, and other common neuro-ophthalmic disorders. There also is a brief explanation of visual field defects.

There is a chapter devoted to external abnormalities with drawings of each explained condition. Treatment also is mentioned in a very few words. There is a three-page chapter on the orbit with a diagram of the frontal view of the orbit with simple

anatomical labeling. Exophthalmos and enophthalmos also are explained in this chapter.

The chapter on slit lamp examination covers the anterior segment with adequate drawings and explanations. This is followed by a chapter on the lens with a brief explanation of cataract surgery and intraocular lenses. Dr. Leitman also has devoted a chapter to glaucoma, superficially covering its diagnosis and treatment.

The last chapter covers the retina and its disorders covering topics in a little more detail than that seen in other chapters. There are several drawings in color illustrating diabetic retinopathy and other common retinal lesions.

Overall, this manual covers the ophthalmic examination in adequate detail for the medical student and even first-year resident outside the field of ophthalmology. It is well written and easy to read for all those interested in eye care.

William H. Constad, M.D.

1987 Year Book of Family Practice

Robert E. Rakel, M.D., (ed). Chicago, IL, Year Book Medical Publishers, Inc., 1987. Pp. 612.

The Year Book of Family Practice is one publication in a rather widely known series of "Year Books." The major difference between this text and others is in the scope of material covered. By the editor's own admission, over 679 journals were reviewed with 400 articles gleaned from 121 of these magazines. This is a rather monumental undertaking and reflects the divergence found in clinical family practice. However, by its very scope, the possibility of significant articles "falling through the cracks" is very real. Be that as it may, the *1987 Year Book of Family Practice* does address a need. In one publication, it provides a broad range of scientifically based articles containing information that should be considered germane to the practice of the contemporary family physician. The articles are of consistent scholarly value and obviously have been selected with some care. They provide a wealth of information about a variety of subjects, and as far as possible for a textbook, represent the state of the art relative to the

scientific and clinical underpinnings of the discipline of family practice.

The only major criticism I would have of the selection of articles is that perhaps they are too academic in their orientation. The clinician, desiring purely practical and day-to-day clinical information, may labor with some of the more esoteric information provided in this collection of papers.

Joseph A. Lieberman, III, M.D.

Office Gynecology. Third Edition

Robert H. Glass (ed). Baltimore, MD, Williams & Wilkins, 1988. Pp. 362. (\$47.95)

Almost every gynecologic problem that might arise in an office or clinic is thoroughly covered in 19 chapters by a host of experts. It would seem likely that a book published in three editions should contain everything you ever wanted to know about office gynecology but were afraid to ask.

Yet, this text, contains too much, e.g. too much space devoted to etiology which belongs more appropriately in a textbook for medical students. There is speculative material that should be aired more appropriately at a panel discussion, e.g. the alleged advantage of new triphasic oral contraceptives over low-dose monophasics. There is dated material that should have been eliminated, e.g. progestins in early pregnancy discredited because of unproved efficacy and fear of litigation over fetal anomalies. The old Papanicolaou classification should have been replaced by the modern nomenclature which is consistent with histology. One contributor encourages private adoptions which might lead to a license suspension in New Jersey for a participating physician. No contributor addresses adequately the problem of the unnecessary high percentage of false negative cytology which is undermining confidence in the best method for detection of early cancer by physicians today.

Most of the material in each chapter is excellent, but errors of commission and omission prevent an unqualified endorsement of this book.

Jerome Abrams, M.D.

Primary Care of the Newborn

Ronald W. Coen, M.D., and Herbert Koffler, M.D. Waltham, MA, Little, Brown & Company, 1987.

Primary Care of the Newborn is a softcover text that focuses on the care and management of the normal newborn. As the authors indicate in the book's preface, more than 90 percent of newborn infants have an uncomplicated perinatal course, yet the major focus of the neonatal literature in the past 20 years has been on the compromised infant. This text attempts to serve as a much needed reference to guide physicians in private practice who care for normal newborns.

The initial three chapters of the book deal with the assessment of pregnancy and labor, the initial physical examination of the newborn infant, and nursery procedures.

The middle three chapters focus on common problems in the first 24 hours of life, special problems in the first 24 hours of life, and assessment and followup beyond the first 24 hours of life. The book discussed these problems on a thorough organ system basis. These three chapters also contain many tables that present valuable information such as the differential diagnosis of respiratory distress, the differential diagnosis of cardiac problems, the time of first defecation and urination, and the evaluation of persistent vomiting.

The next two chapters deal with nutrition and discharge planning and preparation. The last chapter discussed the organization and operation of a level I nursery.

Finally, there is an excellent appendix containing information from normal laboratory values in newborns, to drug dosages, to information on the preparation of formulas.

In general, I feel *Primary Care of the Newborn* is good; it is clearly and concisely written. The text is an excellent reference, especially for medical students, housestaff, and physicians entering private practice for the first time. It also should serve as a good review and reference for those physicians who have been in practice and are well experienced.

Gerald M. Raymond, M.D.

***Drs. Born; Francis; Harris;
Kahn; Kim; Klinger;
Laurenceau; Lucent;
Manrodt; Matyjasik;
McCloskey; Milliser;
Nuraltay; Olmstead; Simon;
Ruppert; Weisman***

Dr. Joseph Born

Family physician and ear, nose, and throat specialist Joseph Born, M.D., 71, retired in Florida since 1982, died on April 11, 1987, after years of practice in Lincoln Park. A native of Paterson, Dr. Born received his medical degree from the University of Arkansas School of Medicine, Little Rock, in 1942. He served on the staffs of Chilton Hospital, Pompton Plains; Barnert Hospital, Paterson; and Riverside Hospital, Boonton. Dr. Born was a member of our Passaic County component and of the American Medical Association.

Dr. Alfred M. Francis

Union City orthopedic surgeon Alfred Martin Francis, M.D., died on December 21, 1987, at the age of 62. Born in Clearfield, Pennsylvania, Dr. Francis was graduated from the University of Louisville School of Medicine, Kentucky, in 1946. Two years after serving as captain in the United States Air Force, Dr. Francis began a Union City private medical practice in 1957, and maintained this practice until his recent passing. He was affiliated with Christ Hospital, Jersey City, as chief of orthopedic surgery; Jersey City Medical Center, as coordinator of orthopedic services from 1968-1973; and Palisades General Hospital, North Bergen. Dr. Francis also was professor at UMDNJ-New Jersey Medical

School, Newark. A Diplomate in orthopedic surgery, Dr. Francis was a member of our Hudson County component.

Dr. Edwin A. Harris

Retired in Easton, Maryland, Moorestown physician Edwin Anderson Harris, M.D., 90, died on December 14, 1987. Born in Dover, Delaware, Dr. Harris received his medical degree from Jefferson Medical College, Philadelphia, in 1920. As well as maintaining a private practice, Dr. Harris was a health officer for Stratford, and school physician for Stratford, Lindenwold, Somerdale, and Gibbsboro. During the 1930s and 1940s, he served as a medical missionary in the Belgian Congo and Nigeria, West Africa. A Fellow of the American Academy for Cerebral Palsy, Dr. Harris was a member of our Burlington County component and of the American Medical Association. In 1970, he was a recipient of the Medical Society of New Jersey's Golden Merit Award, recognizing his 50 years as a physician.

Dr. Leo Kahn

Retired internal medicine specialist Leo Kahn, M.D., died on November 9, 1987, at the age of 80. Born in New York City, Dr. Kahn attended Jefferson Medical College of Philadelphia, where he received his medical degree in 1931. For many years he maintained a private practice in Atlantic City. Dr. Kahn was a member of our Atlantic County component and of the American Medical Association. He received MSNJ's Golden Merit Award in 1981.

Dr. Jae Nam Kim

Diagnostic radiologist Jae Nam Kim, M.D., of Ridgewood, died on January 2, 1988, at the age of 58. A native of Korea, Dr. Kim received his medical degree from Seoul University School of Medicine, Korea, in 1953, and his Ph.D. in anatomy from the University of Minnesota, Minneapolis, in 1959. He served on the staff of Pascack Valley Hospital, Westwood, and was physician for Sharlin Radiology Associates, Hackensack. A Diplomate in diagnostic radiology and in nuclear medicine, Dr. Kim was a member of our Bergen County component and of the American Medical Association.

Dr. Joseph Klinger

Internal medicine specialist Joseph Klinger, M.D., died on January 23, 1988, at the age of 55. A native of New York City, Dr. Klinger received his medical degree from New York University School of Medicine, New York, in 1957. He became affiliated with Alexian Brothers Hospital, Elizabeth General Medical Center, and St. Elizabeth Hospital, all in Elizabeth. Dr. Klinger was a member of our Union County component and of the American Medical Association.

Dr. Victor Laurenceau

Anesthesiologist Victor Laurenceau, M.D., died on October 5, 1987, at the age of 55. Born in Haiti, Dr. Laurenceau received his medical degree from the University of Haiti, in 1955. He became affiliated with North Hudson Hospital, Weehawken, and Bayonne Hospital. A Diplomate in anesthesiology, Dr. Laurenceau was a member of our Hudson County component and of the American Medical Association.

Dr. S. Bell Lucent

Retired family physician S. Bell Lucent, M.D., died on January 23, 1988, at the age of 91. Born in Malta, Great Britain, Dr. Lucent received his medical degree from Cornell University Medical College, New York, in 1921. He lived in Little Falls for 69 years, where he opened a private practice. A Fellow of the American Geriatric Society, Dr. Lucent was a member of our Passaic County component and of the American Medical Association. He was a staff member of Wayne General Hospital. A United States Army veteran, Dr. Lucent served during World War I. In 1971, he was a recipient of MSNJ's Golden Merit Award, honoring his 50 years of medical practice.

Dr. Kurt Manrodt

Cofounder of Chilton Memorial Hospital, Pompton Plains, Kurt Manrodt, M.D., 71, died on January 12, 1988. A Brooklyn, New York native, Dr. Manrodt received his medical degree in 1943 from the University of Pennsylvania School of Medicine, Philadelphia. He opened a Pompton Plains private practice in 1946, after serving as captain in the United States Army medical corps during World War II. Dr. Manrodt

maintained this practice for 40 years. With the intention of providing medical care to the Pompton Plains area, Dr. Manrodt and his uncle, Dr. Forest Spencer Chilton, built Chilton Hospital in 1954. From 1954 to 1986, Dr. Manrodt was a member of the Hospital's Board of Trustees, and became the first chairman of the pediatrics department, president of the medical dental staff, and medical director of sports medicine. Before Dr. Manrodt's retirement in 1986, a pediatric wing was dedicated in his name. Active in his community of Pequannock Township, Dr. Manrodt was school physician, medical director of civil defense, member of the Juvenile Conference Committee, and medical inspector for the Board of Health. For many years of service, Dr. Manrodt was honored in a 1981 Township of Pequannock proclamation. A Fellow of the American Academy of Family Practice, Dr. Manrodt was a member of our Passaic County component and of the American Medical Association.

Dr. Frank M. Matyjasik

Trenton family physician Frank Matthew Matyjasik, M.D., 74, died on January 13, 1988. Born in Trenton, and a lifetime area resident, Dr. Matyjasik received his medical degree from Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania, in 1939. He maintained a family medical practice in Trenton for 45 years, retiring in 1986. Dr. Matyjasik was affiliated with Helene Fuld Medical Center and Hamilton Hospital. He was a member of our Mercer County component and of the AMA.

Dr. John F. McCloskey

John Francis McCloskey, M.D., Director of Pulmonary Medicine at St. Francis Medical Center, Trenton, died on December 13, 1987, at the age of 56. Born in Easton, Pennsylvania, Dr. McCloskey received his medical degree from Temple University School of Medicine, Philadelphia, in 1955. A Diplomate in both pediatric allergy, and allergy and immunology, Dr. McCloskey was a Fellow of the American College of Chest Physicians. He was a member of our Mercer County component and of the American Medical Association. Dr. McCloskey served with the

United States Air Force from 1955 to 1964, emerging with the rank of captain.

Dr. Estelle T. Milliser

Retired general practitioner Estelle Thompson Milliser, M.D., died on January 4, 1988, at the age of 79. A Newark native, Dr. Milliser received her medical degree at the Chicago College of Medicine and Surgery, Illinois, in 1936. She maintained a private practice in Westfield, and became affiliated with Overlook Hospital, Summit. A school physician for South Orange, and later, Westfield, Dr. Milliser was a member of our Union County component and of the American Medical Association. She was a 1986 recipient of MSNJ's Golden Merit Award.

Dr. Ilhan S. Nuraltay

South River internal medicine specialist Ilhan S. Nuraltay, M.D., died on December 19, 1987, at the age of 62. A native of Silistra, Dr. Nuraltay attended the Faculty of Medicine, Bucharest, Romania, where he received his medical degree in 1950. He served on the staffs of UMDNJ-Robert Wood Johnson Medical School and St. Peter's Medical Center, both in New Brunswick, and was assistant professor in research at New York Medical College, New York City. Dr. Nuraltay was a member of our Middlesex County component and of the American Medical Association.

Dr. Edwin V. Olmstead

Retired pathologist Edwin V. Olmstead, M.D., died in Atlanta, Georgia, on December 21, 1987, at the age of 77. He had been retired in Marietta, Georgia, since 1980. Born in South Worcester, New York, Dr. Olmstead received his medical degree from the University of Pennsylvania School of Medicine, Philadelphia, in 1936. He was director of pathology at Hunterdon Medical Center, Flemington, from 1953 to 1975. A Diplomate in clinical pathology, and pathologic anatomy, Dr. Olmstead was a Fellow of the College of American Pathologists, and was a member of our Hunterdon County component and of the American Medical Association. He was a veteran of World War II. In 1986, Dr. Olmstead received MSNJ's Golden Merit Award.

Dr. Ludwig L. Simon

Ludwig Lothar Simon, M.D., retired in Ft. Lauderdale, Florida, following an active medical practice, died at the age of 86, in August 1987. Born in Germany, Dr. Simon was graduated from the University of Cincinnati College of Medicine, Ohio, in 1927. He was on the staffs of Newark Beth Israel Medical Center, Newark, and Clara Maass Medical Center, Belleville. A member of our Essex County component, and of the American Medical Association, Dr. Simon was a Fellow of the American College of Angiology and of the American Geriatric Society. He served during World War II in the United States Air Force, as a major. In 1977, he received MSNJ's Golden Merit Award, for 50 years of medical practice.

Dr. Ralph E. Ruppert

Ralph Edward Ruppert, M.D., of Absecon, died on January 25, 1988, at the age of 65. A Sunnyside, Washington native, Dr. Ruppert received his medical degree from Hahnemann Medical College and Hospital, Philadelphia, in 1948. A Fellow of the American Academy of Family Practice, Dr. Ruppert was school physician for the Pilgrim Academy in Egg Harbor City, and was clinical preceptor for UMDNJ-New Jersey Medical School. Maintaining a practice in Absecon, he was a 40-year area resident. Dr. Ruppert was a United States Army medical corps veteran of the Korean Conflict.

Dr. Stephen L. Weisman

Dermatologist Stephen Lee Weisman, M.D., died on January 13, 1988, at the age of 77. Born in New York City, Dr. Weisman received his medical degree from Rush Medical College, Chicago, Illinois, in 1936. He became affiliated with Wayne General Hospital, eventually serving as chief emeritus of dermatology and allergy. Dr. Weisman maintained private practices in Paterson and Passaic. During World War II, Dr. Weisman was a captain in the United States Army medical corps at the general hospital, Calcutta, India. He was dermatology consultant at Veterans Hospital, Lyons, and was founder and administrator of the Hilltop House and Nursing Home. In 1986, Dr. Weisman received MSNJ's Golden Merit Award.

AUTHOR INFORMATION

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CONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable

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References should not exceed 35 citations except in review articles, and should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8½" by 11" sheets in the numerical order in which they are first cited in the text. The style of reference is that of *Index Medicus*:

1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

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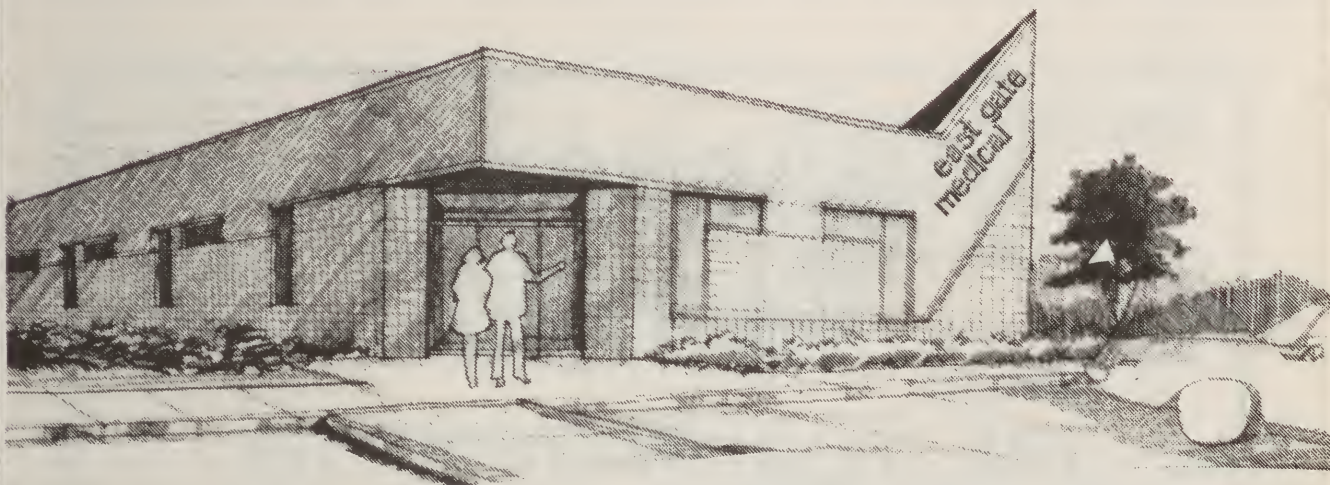
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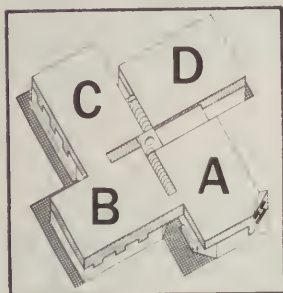


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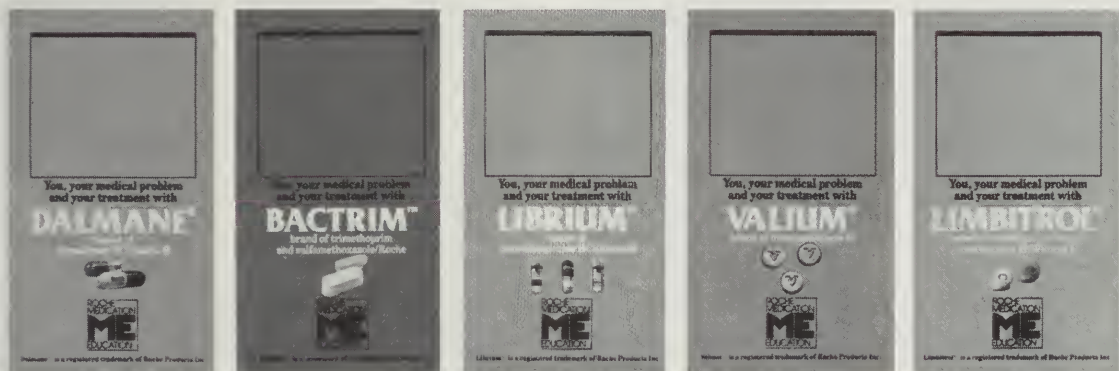


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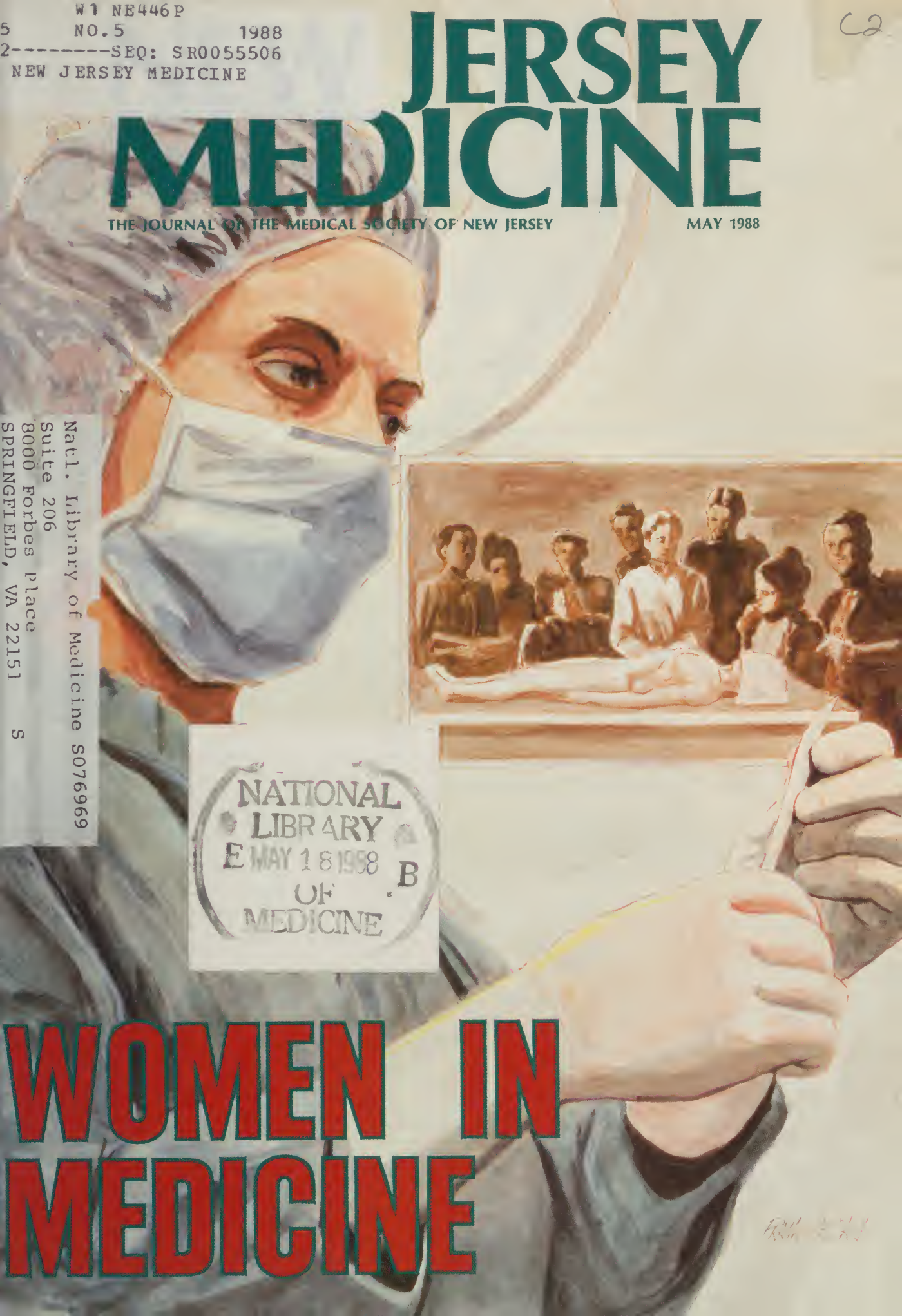
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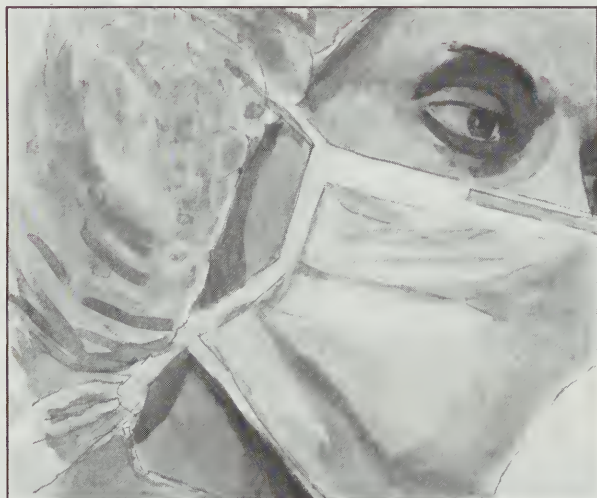
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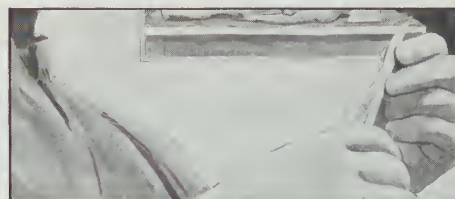
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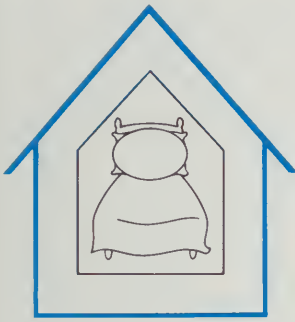
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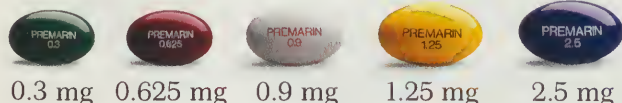
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Three independent, case-controlled studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case-controlled studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semi-annual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equi-estrogenic doses.

2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing, in later life, a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb-reduction defects. One case-controlled study estimated a 4.7-fold increased risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17 α -dihydroequilin, together with smaller amounts of 17 α -estradiol, equilenin, and 17 α -dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe vasomotor symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) Osteoporosis (abnormally low bone mass). Atrophic vaginitis. Kraurosis vulvae. Female castration. PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae.

PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (see Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Estrogens have been reported to increase the risk of endometrial carcinoma (see Boxed Warning). However, a recent large, case-controlled study indicated no increase in risk of breast cancer in postmenopausal women. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism, and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

For atrophic vaginitis

PREMARIN® (conjugated estrogens)

Vaginal
Cream

0.625 mg/g



Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention, such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Pre-existing uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not yet complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

- Increased sulfolobomphthalene retention.
- Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.
- Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T_4 by column, or T_4 by radioimmunoassay. Free T_3 resin uptake is decreased, reflecting the elevated TBG; free T_4 concentration is unaltered.
- Impaired glucose tolerance.
- Decreased pregnanediol excretion.
- Reduced response to metyrapone test.
- Reduced serum folate concentration.
- Increased serum triglyceride and phospholipid concentration.

As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

Long-term, continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. However, in a recent, large case-controlled study of postmenopausal women there was no increase in risk of breast cancer with use of conjugated estrogens.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow, dysmenorrhea; premenstrual-like syndrome, amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis, change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum, hemorrhagic eruption; loss of scalp hair, hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSEAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate-to-severe vasomotor symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 mg to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically.* Osteoporosis: Female castration. Osteoporosis —0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off). Female castration —1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three- to six-month intervals.

Usual dosage range: 2 g to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

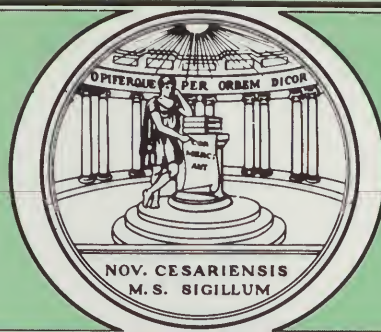
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MEMBERSHIP NEWSLETTER



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THE MEDICAL SOCIETY OF NEW JERSEY

VOLUME 54

NJ LIBRARY FOR THE BLIND & HANDICAPPED Available Services

The best kept secret in New Jersey is the New Jersey Library for the Blind and Handicapped. The staff at the Library has been serving visually impaired and handicapped residents of New Jersey since 1968.

When people develop a visual or physical problem they feel they no longer can continue the activities they enjoyed before the onset of their illness. The physician often is the first person they contact. When patients decide to "get on" with their life, they can take advantage of help that is available to them because their physician has armed them with information.

Any physician interested in having information about the library should contact, Mrs. Christine Lisiecki, New Jersey Library for the Blind and Handicapped, 2300 Stuyvesant Avenue, Trenton, NJ 08618.

NJ DEPARTMENT OF HUMAN SERVICES New and Proposed Rules

The Division of Medical Assistance and Health Services has submitted a proposal concerning administrative charges and service fees which appeared in the March 7, 1988, issue of the *New Jersey Register* at 20 N.J.R. 518(a). The proposal prohibits any Medicaid provider from paying an administrative charge or service fee for the privilege of doing business with another provider. There is one exception to the prohibition. An administrative charge may be allowed for the collection of a copayment (on behalf of pharmacies) from PAAD beneficiaries.

The Division of Medical Assistance and Health Services has submitted a proposed new rule which appeared in the March 7, 1988, issue of the *New Jersey Register* at 20 N.J.R. 519(a). The rule concerns HAAAD

(Hearing Aid Assistance for the Aged and Disabled).

The HAAAD program is completely state funded.

The income eligibility standards are the same as PAAD (Pharmaceutical Assistance for the Aged and Disabled). Individuals can qualify if their income is \$13,650 or less; married persons can qualify if their income is \$16,750 or less. Those persons who are eligible for HAAAD may receive up to \$100 towards the cost of a hearing aid.

The Division of Medical Assistance and Health Services has submitted an emergency rule and concurrent proposal to extend the optionally Categorically Needy Medicaid coverage to the aged, blind, or disabled. The program is known in New Jersey as JerseyCare. A copy of the rule appeared in the March 7, 1988, issue of the *New Jersey Register*.

NEW JERSEY MEDICINE Journalism Award

NEW JERSEY MEDICINE received First Prize in the Annual Medical Journalism Competition, sponsored by Sandoz Pharmaceuticals. Craig D. Burrell, M.D., vice-president of Sandoz Pharmaceuticals stated, "The awards are a reflection of the increasingly high level of design and writing in many health professional publications." The Sandoz awards recognize the unique importance of state and local professional journals and are part of a year-round project to improve journalism techniques among small-circulation, specialized health publications.

FINI

"Happiness is not a matter of good fortune or worldly possessions. It is a mental attitude. It comes from appreciating what we have, instead of being miserable about what we don't have."

CLARK MARTIN*

Courtesy Catches On; Medicaid Movement; Medical Waste: Trouble Ahead

"COURTESY" CATCHES ON

Senior Medical Courtesy, medicine's common sense answer to forced Medicare, is working well and growing throughout the state. More than 3,000 physicians have volunteered to participate in the Courtesy program, accepting Medicare assignment for the treating of 1,200 senior citizens.

A survey taken last month shows county medical societies in 14 of the state's 21 counties have implemented the Courtesy program; 3 counties plan to begin by the end of this month, and 2 more counties are working toward a late summer/early fall startup. This would leave 2 counties, Cumberland and Salem, without the program in place.

The growth of the Courtesy program is both gratifying and politically significant.

The Courtesy program became one of the Society's major weapons in our legislative battle last year against A-2511, the forced Medicare bill. The program gives substance to medicine's assurances that seniors who need medical care will receive it, regardless of their means, from New Jersey's physician community.

Aside from the favorable media attention it has attracted, the Courtesy program continues to represent a more realistic, better conceived alternative to Medicare assignment bills currently pending in the Legislature as A-2305 (Karcher) and S-1649 (Orechio).

Most county societies today report they are using PAAD criteria for determining eligibility for the courtesy program. This sets annual income limits at \$13,650 for single persons and \$16,750 for a married couple.

What makes the Courtesy program superior to other programs is its flexibility. All counties report they look beyond PAAD eligibility to accept applicants whose medical needs consume an excessive amount of available income.

MEDICAID MOVEMENT?

By the end of May, MSNJ should have a firm idea of whether physicians can expect a meaningful change in the state's Medicaid program.

Because provider fees haven't been increased since the early 1970s, the program is dangerously close to not complying with a federal rule that "payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that these services are available to the general population."

In the proposed fiscal 1989 budget now undergoing action in the Legislature, Governor Kean offered a two-way plan to bolster Medicaid. It calls for increased provider fees for office visits as well as the formation of a Medicaid HMO, the Garden State Health Plan.

Unsure whether Medicaid recipients would want to participate in the HMO to any significant extent, the Society's Medicaid Committee has urged that provider fees be raised to levels which will help assure that physicians who treat the poor won't go bankrupt themselves.

In a number of meetings with the Department of Human Services, the Committee has recommended that reimbursement for a routine office visit be raised from the current \$7 to \$14, or the equivalent of 55 percent of the market value of such service, and that proportional increases be made for specialty care. (Pennsylvania last month increased to \$18 its reimbursement for a routine office visit.)

We appear to be making progress, although nothing will be certain until Governor Kean signs the budget on June 30. By then, the Society hopes to report to its members that the Medicaid burden created by years of neglect has become considerably lighter.

MEDICAL WASTE: TROUBLE AHEAD

Looking for ways to prevent ocean and beach pollution, the Legislature has introduced a number of bills which would prohibit sludge dumping, improve storm water and sewage facilities, and beef up the marine police.

One of the bills, A-2853 (Villane), would create a new system for the collection and disposal of medical waste.

If enacted in its current form, the bill would require facilities and private physicians, regardless of office size, to separate refuse into "general medical waste" and "special medical waste." In the first category are items which today are called "trash," such as letters, newspapers, magazines, and boxes. Classified as "special medical waste" would be microbiological culture media, pathology specimens, blood products, and body fluids at least 20 cc in volume.

The legislation would require a physician to: register with the Department of Environmental Protection as a "generator" of waste; identify the name of the trash service ("transporter") which collects the generator's special and general medical waste; and package and distinctively identify trash with the name and address of the generator on the outside of the package.

This potentially expensive new way to handle routine trash could shock New Jersey's physician community. The Society is actively working on the bill.

*Mr. Martin is MSNJ's legislative consultant.

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Action
Tablets

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for success.**

Please see following page for brief summary of prescribing information.

THEO-DUR®

THEOPHYLLINE (Anhydrous)

Sustained Action Tablets

INDICATIONS: THEO-DUR is indicated for relief and/or prevention of symptoms of asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

CONTRAINDICATIONS: THEO-DUR is contraindicated in individuals who have shown hypersensitivity to theophylline or any of the tablet components.

WARNINGS: Status asthmaticus should be considered a medical emergency and is defined as that degree of bronchospasm which is not rapidly responsive to usual doses of conventional bronchodilators. Optimal therapy for such patients frequently requires both additional medication, parenterally administered, and close monitoring, preferably in an intensive care setting.

Although increasing the dose of theophylline may bring about relief, such treatment may be associated with toxicity. The likelihood of such toxicity developing increases significantly when the serum theophylline concentration exceeds 20 mcg/ml. Therefore, determination of serum theophylline levels is recommended to assure maximal benefit without excessive risk.

Serum levels above 20 mcg/ml are rarely found after appropriate administration of recommended doses. However, in individuals in whom theophylline plasma clearance is reduced for any reason, even conventional doses may result in increased serum levels and potential toxicity. Reduced theophylline clearance has been documented in the following readily identifiable groups: 1) patients with impaired renal or liver function; 2) patients over 55 years of age, particularly males and those with chronic lung disease; 3) those with cardiac failure from any cause; 4) neonates; and 5) those patients taking certain drugs (macrolide antibiotics and cimetidine). Decreased clearance of theophylline may be associated with either influenza immunization or active infection with influenza.

Reduction of dosage and laboratory monitoring is especially appropriate in the above individuals. Less serious signs of theophylline toxicity (i.e. nausea and restlessness) may occur frequently when initiating therapy, but are usually transient, when such signs are persistent during maintenance therapy, they are often associated with serum concentrations above 20 mcg/ml. Unfortunately, however, serious side effects such as ventricular arrhythmias, convulsions or even death may appear as the first sign of toxicity without any previous warning. Stated differently: serious toxicity is not reliably preceded by less severe side effects.

Many patients who require theophylline may exhibit tachycardia due to their underlying disease process so that the cause/effect relationship to elevated serum theophylline concentrations may not be appreciated.

Theophylline products may cause dysrhythmia and/or worsen pre-existing arrhythmias and any significant change in rate and/or rhythm warrants monitoring and further investigation.

The occurrence of arrhythmias and sudden death (with histological evidence of necrosis of the myocardium) has been recorded in laboratory animals (minipigs, rodents and dogs) when theophylline and beta agonists were administered concomitantly, although not when either was administered alone. The significance of these findings when applied to human usage is currently unknown.

PRECAUTIONS: THEO-DUR TABLETS SHOULD NOT BE CHEWED OR CRUSHED.

General: Theophylline half-life is shorter in smokers than in non-smokers. Therefore, smokers may require larger or more frequent doses. Morphine and curare should be used with caution in patients with airway obstruction as they may suppress respiration and stimulate histamine release. Alternative drugs should be used when possible. Theophylline should not be administered concurrently with other xanthine medications. Use with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, in the elderly (especially males) and in neonates. In particular, great caution should be used in giving theophylline to patients with congestive heart failure. Frequently, such patients have markedly prolonged theophylline serum levels with theophylline persisting in serum for long periods following discontinuation of the drug. Individuals who are rapid metabolizers of theophylline, such as the young, smokers, and some non-smoking adults, may not be suitable candidates for once-daily dosing. These individuals will generally need to be dosed at 12 hour or sometimes 8 hour intervals. Such patients may exhibit symptoms of bronchospasm near the end of a dosing interval, or may have wider peak-to-trough differences than desired.

Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to the G.I. tract although gastrointestinal symptoms are more commonly centrally mediated and associated with serum drug concentrations over 20 mcg/ml.

Information for Patients: The physician should reinforce the importance of taking only the prescribed dose and time interval between doses. THEO-DUR tablets should not be chewed or crushed. When dosing THEO-DUR on a once daily (q24h) basis, tablets should be taken whole and not split. As with any controlled-release theophylline product, the patient should alert the physician if symptoms occur repeatedly, especially near the end of the dosing interval.

DRUG INTERACTIONS: Drug-Drug: Toxic synergism with epinephrine has been documented and may occur with some other sympathomimetic bronchodilators. In addition, the following drug interactions have been demonstrated:

Drug	Effect
Theophylline with lithium carbonate	Increased excretion of lithium carbonate
Theophylline with propranolol	Antagonism of propranolol effect
Theophylline with cimetidine	Increased theophylline blood levels
Theophylline with troleandomycin, erythromycin	Increased theophylline blood levels

Drug-Food: THEO-DUR 100 mg Sustained Action Tablets have not been adequately studied to determine whether their bioavailability is altered when given with food. Available data suggest that drug administration at the time of food ingestion may influence the absorption characteristics of theophylline controlled-release products resulting in serum values different from those found after administration in the fasting state.

A drug-food effect, if any, would likely have its greatest clinical significance when high theophylline serum levels are being maintained and/or when large single doses (greater than 13 mg/kg or 900 mg) of a controlled-release theophylline product are given.

THEO-DUR (200, 300, and 450 mg) Sustained Action Tablets: The rate and extent of absorption of theophylline from THEO-DUR 200 mg, 300 mg, and 450 mg tablets when administered fasting or immediately after a moderately high fat content breakfast is similar.

Drug-Laboratory Test Interactions: When plasma levels of theophylline are measured by spectrophotometric methods, coffee, tea, cola beverages, chocolate, and acetaminophen contribute falsely high values.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic potential, mutagenic potential, or the effect on fertility of xanthine compounds.

Pregnancy: Category C—Animal reproduction studies have not been conducted with theophylline. It is not known whether theophylline can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Xanthines should be given to a pregnant woman only if clearly needed.

Nursing Mothers: It has been reported that theophylline distributes readily into breast milk and may cause adverse effects in the infant. Caution must be used if prescribing xanthine to a mother who is nursing, taking into account the risk/benefit of this therapy.

Pediatric Use: Safety and effectiveness of THEO-DUR administered:

- 1 Every 24 hours in children under 12 years of age, have not been established.
- 2 Every 12 hours in children under 6 years of age, have not been established.

ADVERSE REACTIONS: The most consistent adverse reactions are usually due to overdose and are:

- 1 **Gastrointestinal:** nausea, vomiting, epigastric pain, hematemesis, diarrhea
- 2 **Central nervous system:** headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions.
- 3 **Cardiovascular:** palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias
- 4 **Respiratory:** tachypnea
- 5 **Renal:** albuminuria, increased excretion of renal tubular and red blood cells, potentiation of diuresis.
- 6 **Other:** rash, hyperglycemia and inappropriate ADH syndrome.

OVERDOSSAGE: Management: If potential oral overdose is established and seizure has not occurred:

- A Induce vomiting
 - B Administer a cathartic (this is particularly important if sustained-release preparations have been taken)
 - C Administer activated charcoal
- If patient is having a seizure:
- A Establish an airway
 - B Administer oxygen
 - C Treat the seizure with intravenous diazepam, 0.1 to 0.3 mg/kg up to 10 mg.
 - D Monitor vital signs, maintain blood pressure and provide adequate hydration.

Post Seizure Coma:

- A Maintain airway and oxygenation
- B If a result of oral medication, follow above recommendations to prevent absorption of the drug, but intubation and lavage will have to be performed instead of inducing emesis, and the cathartic and charcoal will need to be introduced via a large bore gastric lavage tube
- C Continue to provide full supportive care and adequate hydration while waiting for drug to be metabolized. In general, the drug is metabolized sufficiently rapid so as not to warrant consideration of dialysis, however, if serum levels exceed 50 mcg/ml charcoal hemoperfusion may be indicated.

CAUTION: Federal law prohibits dispensing without prescription. For full prescribing information, see package insert.

Revised 6/87

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Malpractice Crises

***Stress Boosts Malpractice Risk;
Existing JUAs in Trouble; California
Compromise Could Rekindle Desire
To Seek Huge Awards***

STRESS BOOSTS MALPRACTICE RISK

Cutting job stress and departmental discord can slash the incidence of malpractice, suggest researchers who studied 56 midwestern hospitals.

St. Paul Insurance Companies analysts found stress a strong predictor of malpractice, John Jones, the firm's chief industrial psychologist, reported at an AMA conference on impaired health professionals. Departments with the highest stress levels accounted for 80 percent of malpractice occurrences.

Stress-management programs targeted to those departments reduced malpractice claims from an average of 1.64 per hospital in 1985 to 0.41 in 1986, the analysts found.

If stressful events in employees' lives or conflicts within the organization interfere with the ability to concentrate on work, people make more mistakes, Jones said. Though substance abuse is "almost always tied" to impaired teams, it aggravates rather than causes malpractice situations.

Impaired teams are even more predictive of malpractice claims than are impaired individuals, he reported. "It's not Mary or Bob who are impaired and doing all the damage. It is a shared value system within a dysfunctional work unit. Departments use one or two individuals' impairment as a crutch, but when we study the situation, [we find] a poorly managed, low-morale team."

Jones described an "organizational climate of malpractice" that includes four problem areas:

- Lack of support from management, coworkers, and technology.
- Too small a staff, with employees who are overworked and under seemingly unbearable deadline pressure.

- Counterproductivity, stemming from substance abuse, theft, rule breaking, or disregard for treatment plans.
- Chronic deep emotional stress manifesting as apathy and fatigue.

In the controlled study, the St. Paul Insurance Companies team surveyed every hospital employee and then compiled each department's total stress and satisfaction levels and compared them with national norms. They provided stress-management training for hospital administrators and managers and then compared the malpractice claims occurrences for the years before and after stress-reduction programs were instituted.

"The survey allowed us to zero in on high-risk departments," Jones said. "In a hospital with 40 departments, I could tell the administrators which three they absolutely had to get to work on" and give "hints about what was going on." Problem locations were "idiosyncratic to institutions" and not most common in high-risk areas such as emergency or intensive care units.

In two-day training sessions, the team taught managers "how to manage troubled employees, lower stressors, and excessive deadline pressure, and build teamwork and a more caring attitude toward patients," said Bruce Barge, who's an industrial and organizational psychologist for the insurance company.

AMA senior deputy vice-president, James Todd lauded the attempt to "help hospitals and physicians learn to diminish and deal with stress" and predicted that soon "we'll be talking about stress-impaired physicians as we now talk about the chemically impaired." But he cautioned against placing too much credibility on a single year's statistics.

St. Paul Insurance Companies now are studying "various assessment and education strategies to help physicians see their own risk factors," Barge said. "Lots of things put physicians at risk for negligence, including emotional problems and senility. The spectrum of impairment is wider than just chemical and substance abuse. We aim to develop a variety of tools to help physicians understand whether they stand on a path that might lead to impairment. We want to get to them before it becomes a problem.

Physicians are among those least likely to seek counseling, because they do not know where to go and are not socialized to think it's acceptable, says clinical physiologist Cynthia D. Scott, a consultant who works with the insurance company's human factors institute. She has developed a "map" that plots stress and coping mechanisms. It is being pilot tested at several centers. In one study, psychiatric residents who recognized their stress patterns by means of the map were able to decrease stress by 74 percent, she said. (*Medical World News*, November 9, 1987)

EXISTING JUAs IN TROUBLE

Five of the ten existing state joint underwriting associations (JUAs) established in the 1970s are estimated to have insufficient funds to cover existing

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are Director of the Department, and Director of Special Projects, respectively.

Scale for Plaintiff Attorney Contingency Fees

Under MICRA reform legislation

40% of first \$50,000 =	\$20,000
33⅓% of next 50,000 =	16,666
25% of next 100,000 =	<u>25,000</u>

Fee on \$200,000 recovery =	\$61,666
10% of any amount over \$200,000	

Under new fee schedule

40% of first \$50,000 =	\$ 20,000
33⅓% of next 50,000 =	16,666
25% of next 500,000 =	<u>125,000</u>

Fee on \$600,000 recovery =	\$161,666
15% of any amount over \$600,000	

Examples of Change in Fee	Under MICRA	New Fee	Percent Increase
\$ 150,000 recovery	\$ 49,166	\$ 49,166	No Change
\$ 200,000 recovery	\$ 61,666	\$ 61,666	No Change
\$ 300,000 recovery	\$ 71,666	\$ 86,666	20.9%
\$ 500,000 recovery	\$ 91,666	\$136,666	49.1%
\$ 750,000 recovery	\$116,666	\$184,666	58.3%
\$1,000,000 recovery	\$141,666	\$221,666	56.5%
\$2,000,000 recovery	\$241,666	\$371,666	53.8%
\$3,000,000 recovery	\$341,666	\$521,666	52.7%

claim liabilities, according to an Alliance of American Insurers report. The JUAs were created and in some cases, funded by state governments during the malpractice crisis of the 1970s, so that medical liability coverage could be written in these areas. Half of the JUAs—South Carolina, New York, New Hampshire, Rhode Island, and Massachusetts—now report shortfalls, ranging from approximately \$4 million in South Carolina to more than \$182 million in Massachusetts.

The reason for the shortfalls, according to Roger K. Kenney, Alliance research manager and author of the report, is because "claims liabilities are accruing at a faster rate than funds are coming in." Kenney commented on the negative impact of the JUA deficiencies. "Unfortunately, additional funds for the financially deficient JUAs will have to come from somewhere, whether it's the insurance industry, health care providers, or policyholders," he stated.

The other five JUAs, Florida, Kansas, Pennsylvania, Texas, and Wisconsin, are expected to meet claim liability payout demands if investment yields are maintained and current reserves are adequate. This forecast may be overly optimistic, however, given the volatility of the economy and the unprecedented increase in number and size of medical malpractice claims.

The report may be obtained from the Alliance of American Insurers, 1501 Woodfield Road, Suite 400 West, Schaumburg, IL 60173. Requests should be directed to Roger K. Kenney and specify the Alliance report entitled, *Financial Condition of Medical Malpractice JUAs*. (*Professional Liability Update*, November 1987)

CALIFORNIA COMPROMISE COULD REKINDLE DESIRE TO SEEK HUGE AWARDS

The ink was barely dry on the "cease-fire" agreement on tort reform worked out between California physicians, a business coalition, and trial lawyers, and encapsulated in a bill slammed through the Assembly in its closing hours when it became clear to some that the "deal" may not be such a good deal after all.

The agreement, which came in the wake of frantic last-minute negotiations in the California Assembly last September, preserves California's Medical Injury

Compensation Reform Act (MICRA) and sets a five-year moratorium on legislative or other efforts to make any changes in it. But the deal also incorporates some adjustments in fees payable to plaintiffs' attorneys.

After analyzing the impact of the changes in the contingency fee scale, the Medical Insurance Exchange of California (MIEC) says the "adjustments" are not so minor after all. The fee increases range from 0 percent for recoveries up to \$200,000, 58.3 percent for a \$750,000 recovery, 56.5 percent for a \$1 million recovery, 53.8 percent for a \$2 million recovery, to 52.7 percent for a \$3 million recovery.

"The plaintiff attorneys have succeeded in reinstating the jumbo jackpot fee which existed in 1975 (before passage of MICRA) and which is the engine that drove the growth of tort law excesses of the past 30 years," Bill Scheuber, MIEC president, told *Medical Liability Monitor*.

First reports of the legislative deal were that some "slight adjustments" had been made in the MICRA provision that sets a sliding scale for attorneys' contingency fees, with the percentage to the lawyer increasing from 10 to 15 percent for awards over \$600,000. MIEC's analysis suggests that the stakes are driven even higher as the award escalates.

There is fear that the new fee schedule again will motivate attorneys to withhold settlement, to concoct bad faith and punitive damage allegations, and new and "imaginative" causes of action, Scheuber warned.

"It also does nothing to improve injured party access to legal help in case of small damages, and preserves the inequity of large pay for little work in cases of large damages and clear liability," he said. "With relaxed limits, we fear the abuses will return."

Scheuber said one plaintiff attorney summed up his pleasure by saying "with this raise in pay, we'll get back in business."

Scheuber also said some are wondering how many cracks will appear in the five-year moratorium. Already the trial bar has said it is not happy with the compromise and defense attorneys also are restive about the plan. Consumers may be next to complain. (*Medical Liability Monitor*, November 25, 1987, Vol. 12, Number 11)

Ulcer therapy that won't yield, even to smoking

YIELD



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*Significantly greater than cimetidine smoker group ($P < .05$).

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BRIEF SUMMARY

CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate.

PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

Pregnancy: Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

OVERDOSAGE

There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED

CARAFATE (sucralfate) 1-gm tablets are supplied in bottles of 100 (NDC 0088-1712-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1712-49). Light pink scored oblong tablets are embossed with CARAFATE on one side and 1712 bracketed by C's on the other.

Issued 1/87

References:

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From the Beginning




Dr. Palma Formica visits a patient in the intensive care unit.

Topics of great interest come and go over time; in today's world, the position of women has become the source of scholarly searching and intense contemplation. As women gain one height after another in medicine, a view of the problems their predecessors faced and the ways they solved them is instructive. The inauguration of Palma Formica, MD, as the first woman president of the oldest medical society in the United States, provides the impetus for the examination of this topic.

To set the scene, Dr. Regina Morantz-Sanchez uses her 1988 Morris Saffron Lecture for a picture of women and medicine in the late 19th and early 20th centuries. Dr. Estelle Brodman narrows the field to New Jersey in her demographics on women physicians throughout the past century. Drs. Suzanne Widrow and Christine Haycock describe the founding of the New Jersey component of the American Medical Women's Association and the physicians who labored in the work of legitimization, congeniality, and social services. Laurie A. Barrood interviews Dr. Formica on the eve of her inauguration and Stan Godlewski presents a photo essay of Dr. Formica. Dr. Elizabeth Alger and Ms. Barrood study women physicians in education. Barbara Smith Irwin provides information on state sources for further study of a topic which affects all recipients of health care in New Jersey.

New Jersey has had a goodly share of outstanding physicians, most of whom charted new courses by breaking down the barriers against women. A series of articles on "First Ladies" follows: Dr. Eva Brodtkin, the first woman dermatologist by Dr. Morris Saffron; Dr. Jeanette Munro, the first woman pediatrician from her unpublished autobiography; Dr. Rita S. Finkler, the first woman endocrinologist by Dr. Sylvia Becker; Dr. Lena Edwards, the first board-certified obstetrician and gynecologist by Linda Holmes; and Dr. Sarah F. Mackintosh, the first woman member of the Medical Society of New Jersey by Geraldine Hutner.

Publication of this issue of NEW JERSEY MEDICINE was aided by a grant from the  New Jersey Committee for the Humanities. The views expressed herein are not necessarily those of the New Jersey Committee for the Humanities. Special thanks to La Verne Fioretti for planting the idea for the creation of this project.

Estelle Brodman, PhD, Guest Editor



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AUTHOR INFORMATION

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CONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

COMMUNICATIONS

All communications should be sent to the Editor, *New Jersey Medicine*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

For urinary tract infection

Illustration of
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in urinary tract
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Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole/Roche)

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Please see references and summary of product information on following page.

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Bactrim™

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Before prescribing, please consult complete product information, a summary of which follows:
CONTRAINDICATIONS: Hypersensitivity to trimethoprim or sulfonamides; documented megaloblastic anemia due to folate deficiency; pregnancy at term and during the nursing period; infants less than two months of age.

WARNINGS: FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS.

BACTRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. Clinical signs, such as rash, sore throat, fever, arthralgia, cough, shortness of breath, pallor, purpura or jaundice, may be early indications of serious reactions. In rare instances a skin rash may be followed by more severe reactions, such as Stevens-Johnson syndrome, toxic epidermal necrolysis, hepatic necrosis or serious blood disorder. Perform complete blood counts frequently. **BACTRIM SHOULD NOT BE USED IN THE TREATMENT OF STREPTOCOCCAL PHARYNGITIS.** Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have a greater incidence of bacteriologic failure when treated with Bactrim than with penicillin.

PRECAUTIONS: General: Give with caution to patients with impaired renal or hepatic function, possible folate deficiency (e.g., elderly, chronic alcoholics, patients on anticonvulsants, with malabsorption syndrome, or in malnutrition states) and severe allergies or bronchial asthma. In glucose-6-phosphate dehydrogenase deficient individuals, hemolysis may occur, frequently dose-related.

Use in the Elderly: May be increased risk of severe adverse reactions in elderly, particularly with complicating conditions, e.g., impaired kidney and/or liver function, concomitant use of other drugs. Severe skin reactions, generalized bone marrow suppression (see WARNINGS and ADVERSE REACTIONS) or a specific decrease in platelets (with or without purpura) are most frequently reported severe adverse reactions in elderly. In those concurrently receiving certain diuretics, primarily thiazides, increased incidence of thrombocytopenia with purpura reported. Make appropriate dosage adjustments for patients with impaired kidney function (see DOSAGE AND ADMINISTRATION).

Use in the treatment of Pneumocystis Carinii Pneumonia in Patients with Acquired Immunodeficiency Syndrome (AIDS): AIDS patients may not tolerate or respond to Bactrim in same manner as non-AIDS patients. Incidence of side effects, particularly rash, fever, leukopenia, elevated aminotransferase (transaminase) values, with Bactrim in AIDS patients treated for *Pneumocystis carinii* pneumonia reported to be greatly increased compared with incidence normally associated with Bactrim in non-AIDS patients.

Information for Patients: Instruct patients to maintain adequate fluid intake to prevent crystalluria and stone formation.

Laboratory Tests: Perform complete blood counts frequently; if a significant reduction in the count of any formed blood element is noted, discontinue Bactrim. Perform urinalyses with careful microscopic examination and renal function tests during therapy, particularly for patients with impaired renal function.

Drug Interactions: In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombocytopenia with purpura has been reported. Bactrim may prolong the prothrombin time in patients who are receiving the anticoagulant warfarin. Keep this in mind when Bactrim is given to patients already on anticoagulant therapy and reassess coagulation time. Bactrim may inhibit the hepatic metabolism of phenytoin. Given at a common clinical dosage, it increased the phenytoin half-life by 39% and decreased the phenytoin metabolic clearance rate by 27%. When giving these drugs concurrently, be alert for possible excessive phenytoin effect. Sulfonamides can displace methotrexate from plasma protein binding sites, thus increasing free methotrexate concentrations.

Drug/Laboratory Test Interactions: Bactrim, specifically the trimethoprim component, can interfere with a serum methotrexate assay as determined by the competitive binding protein technique (CBPA) when a bacterial dihydrofolate reductase is used as the binding protein. No interference occurs if methotrexate is measured by a radioimmunoassay (RIA). The presence of trimethoprim and sulfamethoxazole may also interfere with the Jaffe alkaline picrate reaction assay for creatinine, resulting in overestimations of about 10% in the range of normal values.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Carcinogenesis: Long-term studies in animals to evaluate carcinogenic potential not conducted with Bactrim. **Mutagenesis:** Bacterial mutagenic studies not performed with sulfamethoxazole and trimethoprim in combination. Trimethoprim demonstrated to be nonmutagenic in the Ames assay. No chromosomal damage observed in human leukocytes *in vitro* with sulfamethoxazole and trimethoprim alone or in combination; concentrations used exceeded blood levels of these compounds following therapy with Bactrim. Observations of leukocytes obtained from patients treated with Bactrim revealed no chromosomal abnormalities. **Impairment of Fertility:** No adverse effects on fertility or general reproductive performance observed in rats given oral dosages as high as 70 mg/kg/day trimethoprim plus 350 mg/kg/day sulfamethoxazole.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Trimethoprim and sulfamethoxazole may interfere with folate metabolism; use during pregnancy only if potential benefit justifies potential risk to fetus. Nonteratogenic Effects: See CONTRAINDICATIONS section.

Nursing Mothers: See CONTRAINDICATIONS section.

Pediatric Use: Not recommended for infants under two months (see INDICATIONS and CONTRAINDICATIONS sections).

ADVERSE REACTIONS: Most common are gastrointestinal disturbances (nausea, vomiting, anorexia) and allergic skin reactions (such as rash and urticaria). **FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS (SEE WARNINGS SECTION).** **Hematologic:** Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, neutropenia, hemolytic anemia, megaloblastic anemia, hypoprothrombinemia, methemoglobinemia, eosinophilia. **Allergic Reactions:** Stevens-Johnson syndrome, toxic epidermal necrolysis, anaphylaxis, allergic myocarditis, erythema multiforme, exfoliative dermatitis, angioedema, drug fever, chills, Henoch-Schoenlein purpura, serum sickness-like syndrome, generalized allergic reactions, generalized skin eruptions, photosensitivity, conjunctival and scleral injection, pruritus, urticaria and rash. Periarteritis nodosa and systemic lupus erythematosus have been reported. **Gastrointestinal:** Hepatitis (including cholestatic jaundice and hepatic necrosis), elevation of serum transaminase and bilirubin, pseudomembranous enterocolitis, pancreatitis, stomatitis, glossitis, nausea, emesis, abdominal pain, diarrhea, anorexia. **Genitourinary:** Renal failure, interstitial nephritis, BUN and serum creatinine elevation, toxic nephrosis with oliguria and anuria, crystalluria. **Neurologic:** Aseptic meningitis, convulsions, peripheral neuritis, ataxia, vertigo, tinnitus, headache. **Psychiatric:** Hallucinations, depression, apathy, nervousness. **Endocrine:** Sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents; cross-sensitivity may exist. Diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. **Respiratory:** Pulmonary infiltrates. **Musculoskeletal:** Arthralgia, myalgia. **Miscellaneous:** Weakness, fatigue, insomnia.

DOSAGE AND ADMINISTRATION: Not recommended for use in infants less than two months of age. **URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:** Usual adult dosage for urinary tract infections is one DS tablet, two tablets or four teaspoonfuls (20 ml) b.i.d. for 10 to 14 days. Use identical daily dosage for 5 days for shigellosis. **Recommended dosage for children with urinary tract infections or acute otitis media:** Is B mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses every 12 hours for 10 days. Use identical daily dosage for 5 days for shigellosis. **Renal Impaired:** Creatinine clearance above 30 ml/min, give usual dosage; 15-30 ml/min, give one-half the usual regimen; below 15 ml/min, use not recommended.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS: Usual adult dosage is one DS tablet, two tablets or four teasp. (20 ml) b.i.d. for 14 days. **PNEUMOCYSTIS CARINII PNEUMONIA:** Recommended dosage is 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

HOW SUPPLIED: DS (double strength) Tablets (160 mg trimethoprim and 800 mg sulfamethoxazole)—bottles of 100, 250 and 500; Tel-E-Dose® packages of 100; Prescription Packs of 20. **Tablets** (80 mg trimethoprim and 400 mg sulfamethoxazole)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Packs of 40. **Pediatric Suspension** (40 mg trimethoprim and 200 mg sulfamethoxazole per teasp.)—bottles of 100 ml and 16 fl. oz. (1 pint). **Suspension** (40 mg trimethoprim and 200 mg sulfamethoxazole per teasp.)—bottles of 16 oz (1 pint).

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June 11, 1988

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Not Feminized but Humanized

REGINA MORANTZ-SANCHEZ, PhD



Figure 1. Elizabeth Blackwell, the first woman to receive a medical degree in the United States. (Published with permission. Copyright Archives and Special Collections on Women in Medicine.)

Years ago, when I was in the midst of writing *Sympathy and Science*, I often was invited to speak at medical schools by sympathetic and worried deans who wanted to do something positive for their female students: to give them a sense of their own past. Learning about how women physicians had “coped” in previous generations might stimulate thought and discussion, as well as

aid students in making the difficult transition from woman to professional. My audiences, which were composed primarily of women, were responsive.

Dr. Morantz-Sanchez is the Morris H. Saffron Lecturer for 1988. Requests for reprints can be addressed to Dr. Morantz-Sanchez, 4400 Tomahawk Road, Prairie Village, Kansas 66208.

With their numbers increasing in medical schools, and given the special female qualities women bring to the profession, will women indeed change medicine?

During the question-and-answer period that usually followed, I often was asked one question in particular: With their numbers increasing in medical schools, and given the special "female" qualities that women bring to the profession, will women indeed change medicine? Of course, I always found this question the hardest of all to answer, partly because it is the business of historians to write about the past, not to predict the future. As I groped for a reply, the same theme always shaped my responses. I heard myself saying that if entering medicine meant that women physicians would cease to make the bearing and raising of children a central activity of their lives, then their presence probably would not change the way medicine was organized and practiced at all. Indeed, medicine probably would transform them, by teaching them how to become successful professionals. They would likely readily adopt the ethos and behavior of their male colleagues, and prove that men and women in fact, can be equally accomplished medical practitioners. At the time, I was unaware of why I kept coming back to those same conclusions. My response also troubled me somewhat, because it seemed to link women's biology with a special responsibility to rear children, and implied that women innately harbor special qualities of nurturance. Furthermore, since I really didn't believe that large numbers of women in any profession would stop having children, my answer also suggested that women physicians, in spite of their increasing numbers, might still be so burdened by childbearing that they would remain professionally marginal. As unsatisfying as this response was to me at the time, I kept falling back on it. Only lately, have I begun to suspect that it was not so far off the mark. Indeed, a recent foray into feminist theory has helped me to better formulate those early ideas, and I hope to bring this body of thought to bear in the following discussion of women's past and future role in medicine.

Several different approaches to this important subject are possible. One that readily comes to mind is structural and organizational. I could discuss the meaning of women's preference for salaried positions over private practice, their willingness to choose primary care specialties, the declining prestige and economic clout of the independent practitioner, and how such changes in the past have been linked to the "feminization" of a profession. These are all pressing issues that have profound implications for

social policy and future planning. But my sense is that the average physician is inundated with literature on such topics. Consequently, I prefer a more philosophical posture.

My inclination is to examine the relevance of history to present dilemmas. First, historically, what have been women's contributions to medicine? Have women doctors adjusted themselves uncritically to 20th-century medical professionalization, happy and content to be welcomed as members of the club? Or have some offered an alternative vision of how medicine might be organized and practiced? Second, how can we better understand and interpret this past in the light of feminist theory today? For the last decade feminism has mustered its own critique of medical practice. How much of that critique is justified, and what does it say to male and female practitioners? And, by virtue of their past, what can women doctors today contribute to the healthy self-criticism taking place within the profession, and what particular approaches, if any, can be identified with them?

THE HISTORY OF WOMEN IN MEDICINE

Between 1750 and 1850, industrialization transformed family life and the social meaning of gender roles. Especially important was the appearance of an ideology of domesticity that glorified the separation of the home and public life and extolled the female qualities of nurturing, moral superiority, and maternity. Henceforth, the world of men would be labelled "the public sphere," while the world of women was viewed as "private." Though this ideology appeared at least superficially to reaffirm woman's traditional connection with the home, it equally promised radical change. Women actually gained extraordinary new power in the private sphere, power which they did not have in the patriarchal family economy of the preindustrial period. As the family was romanticized, women were depicted increasingly at its moral and spiritual center. They were assigned a central role in the preservation of values intended to inform, not only family life, but the social institutions for society at large. Suddenly women's role was invested with cosmic moral significance. In time, many women used their new moral power to assert themselves into public life. In doing so, they played an important part in 19th century social reform. Such activity paved the way first for women's education, and then for their entrance into

professions like teaching, medicine, social work, librarianship, nursing, and, in the 20th century, law.

Women doctors were among those 19th-century female activists who worked to carry domestic values into the public sphere. Armed with their belief in women's natural gifts as healers and nurturers, they envisioned themselves as physicians who could combine "feminine" sympathy with "masculine" science. Indeed, Elizabeth and Emily Blackwell called women physicians the "connecting link" between the science of the medical profession and the everyday life of women, arguing that they were "for the purpose of occupying positions men cannot fully occupy, and exercising an influence which men cannot wield at all."¹

But why was "science" increasingly viewed as "masculine" at the end of the 19th century? An answer to this question lately has been offered by historians of science, who have begun to study the evolution of the contemporary ideology of science. These scholars have vividly described how scientists from the 17th century on gradually succeeded in legitimating an approach to knowledge which was allegedly dispassionate, precise, and subject to suitable tests of proof. Building on this fascinating work, feminist scholars have shown how the language of science served, not only to validate a specific kind of inquiry—for example, laboratory experiments under suitable controls, the precise measuring and counting of results, the repetition of protocols, and the publication of findings—but also denigrated and devalued more subjective and informal modes of knowing. Francis Bacon, one of the founders of modern science, filled his writings with patriarchal metaphors depicting mind as masculine, nature as feminine, and science as a marriage between the two. Devoid of mind, nature was to be conquered, subdued, and controlled. Gradually, more subjective forms of knowledge, which had played an important role in traditional branches of medieval science like alchemy, persistently became identified with the feminine. The result is a legacy of gendered cultural dichotomies with which we are all very much familiar—dichotomies like male/female, objective/subjective, culture/nature, active/passive, rational/emotional, and public/private.²

Contemporary feminist theorists have begun to ferret out the destructive, even dangerous aspects of this intellectual legacy, not only for our culture, but for the pursuit of science itself. In particular, they have challenged the sharp opposition between "masculine" reason and "feminine" intuition. They have critiqued the philosophical assumptions asserting that women's close connection with organic life has kept them from the world of reason, and they carefully have scrutinized the relationship between what most women "do" in our society and intuitive,

more subjective ways of knowing. Though there is a growing literature on this subject, I would like to look just briefly at this strain of feminist thinking in order to gain some insight into the historical legacy of women physicians.^{3,8}

In an important article entitled "Maternal Thinking," the philosopher Sara Ruddick proposes to revise common assumptions about mothering which contrast the abstract and formal ideas of men's traditional explorations with the more "informal" modes of thought involved in childrearing. She takes special issue with an underlying tenet of this dualistic thinking—the idea that because society has relegated mothering to a private, less structured and more "natural" sphere of existence, a mother's knowledge is not as legitimate or as acceptable as what men do. She proposes instead, that a mother "engages in a discipline" just as systematic as the pursuit of medicine or law, that reason is an essential component of a mother's knowledge, and that "maternal thinking" is an activity which deserves to have its forms recognized. Indeed, she goes one step further: she suggests that analyzing and describing this type of thought—a form of knowing shaped by maternal practices—can lead eventually toward the creation of a new public ethic with a greater emphasis on caring.⁹

Ruddick is not alone among those who have taken issue with the presumption that legitimate reasoning occurs only within the realm of masculine activities like science and mathematics. Several scholars have shown that the devaluation of women's intuition derives from a more general cultural suspicion of all forms of knowledge which are nonscientific. Moreover, recent developments in a wide range of disciplines have demonstrated the inadequacy of using the scientific model as an absolute measure of what counts as knowledge.¹⁰ Many scholars are calling for a redefinition of the notions of subjectivity and objectivity. They argue, for example, that women's activities in the domestic sphere, particularly childrearing, require preparation, foresight, experience, training, and, ultimately, the ability to reason. Of course, most mothers love their children and respond to their needs. But that response is not random or automatic. Even maternal feelings are not instinctive, but the product of thought, knowledge, and experience. In the process of living with children, mothers, Ruddick argues, "acquire a conceptual scheme—a vocabulary and logic of connections through which they order and express the facts and values of their practice." This knowledge and experience exhibits a much greater emphasis on the particular and the individual than does that of a mathematician or theoretical physicist. Indeed, because much of mothering entails the fostering of emotional and intellectual growth, a duty which re-

quires responding to a being (object) which is continually growing, changing, and intentionally moving away, a mother's task involves a willingness and ability to gradually alter her relationship with her child. "The idea of 'objective reality' itself," Ruddick observes, paraphrasing philosopher and novelist Iris Murdoch, "undergoes important modification when it is to be understood, not in relation to 'the world described by science,' but in relation to the progressing life of a person." It is this "unity of reflection, judgment, and emotion" which Ruddick labels "maternal thinking."

Ruddick's article is one of several recent attempts to critique and ultimately modify the radical separation between subject and object that has become characteristic of scientific thinking in the last 300 years.

Scholars who share Ruddick's approach seek nothing less than the incorporation into scientific discourse of a different form of knowing, one which makes effective use of subjective experience. For example, the physicist, Evelyn Fox Keller argues that objectivity as it has been previously understood, is too "static." It begins with the erroneous assumption that one in fact can sever oneself completely from the object of study, and hence regard one's investigations as unbiased and absolute. She proposes instead an expanded mode of knowing which she calls "dynamic objectivity." Its aim is to grant "to the world around us its independent integrity," but to do so "in a way that remains cognizant of, and indeed relies on, our connectivity with that world." Keller seeks a special kind of empathy, "a form of knowledge of other persons that draws explicitly on the commonality of feelings and experience in order to enrich one's understanding of another in his or her own right."³

None of these thinkers believe that such a form of knowing is dependent on women's biology or even always is female. They argue only that women in our society usually are taught maternal thinking, while men are not. Some scholars have connected such thought patterns to minority groups—blacks and Chicanos, for example—and suggest that this special form of empathy arises from the experience of subordination. Whatever its origin, the object of



Figure 2. Palma E. Formica, MD, the first woman president of the Medical Society of New Jersey.

their analysis is to abstract such thinking temporarily from its social context and measure it against more traditional methods of scientific inquiry. Feminists argue that traditional objectivity actually constrains science, and offer an alternative paradigm which stresses the interaction between the knower and the known. The goal is an expanded and more effective theory of knowledge—one which can better accommodate, not only the pursuit of science, but the develop-

ment of a more holistic and life affirming culture.

If it seems I have moved far afield from the subject of women doctors, it has been a digression with a purpose. My argument is that contemporary feminist and philosophical theory can help us better understand women physicians' past approach to the organization and practice of medicine and can explain why some of them had difficulty adjusting to 20th-century medical professionalization. Perhaps, too, such theory can help guide women physicians today as they struggle with the question of their role in medicine.

With the bacteriological revolution at the end of the 19th century, women doctors confronted a tension between sympathy and science in medicine—a tension which they themselves helped make a public issue.

Women physicians had entered the profession believing in women's abilities to alleviate pain and suffering. They had wrestled with their dual identities as women and as doctors. They had emphasized the importance of prevention over cure and the duty of doctors to bring about social reform. Yet, until bacteriology injected a specific kind of science into medical practice, they functioned in an atmosphere colored by an older concept of professionalism, accepted by both sexes, which maintained a place for subjective forms of knowing and stressed the therapeutic powers of moral and social concerns.¹²

Elizabeth Blackwell, for example, taught that every good physician, male or female, must possess what she called "the spiritual power of maternity." Although she once called motherhood a "remarkable specialty," it was not merely "the material aspect" of motherhood which intrigued her. Indeed, she emphasized that it was a mistake to view motherhood purely in its physical sense. What made

mothering so compelling was the "spiritual principles" which underlay the ordinary tasks that most mothers daily performed. Indeed, for Blackwell, maternity had much in common with Erik Erikson's idea of generativity, a concept that he defines as "the concern in establishing and guiding the next generation." Like Erikson, Blackwell interpreted the "spiritual power" of maternity in the broadest possible terms. Not only physicians, but all mankind must learn the lessons it had to teach, whether individuals actually had children or not. And what were these lessons? "The subordination of self to the welfare of others; the recognition of the claim which helplessness and ignorance make upon the stronger and more intelligent; the joy of creation and bestowal of life; the pity and sympathy which tend to make every woman the born foe of cruelty and injustice; and hope . . . which foresees the adult in the infant, the future in the present." These, Blackwell insisted, were great "moral tendencies"; they were insights derived from the social practices of mothering, and they could not be measured or reproduced in the laboratory.¹³⁻¹⁵

In her emphasis on the spiritual power of maternity, I believe Blackwell was making a case for the importance of "maternal thinking" to medical therapeutics. Outside of the domestic life itself, she wrote in 1891, there was no other occupation as noble as the practice of medicine. But medical study involved the preservation of qualities—"tenderness, sympathy, guardianship,"—which she identified with mothering. The skills women learned in caring for children must be taught to everyone, especially physicians. These, combined with the more objective methods of scientific inquiry, formed the essence of what Blackwell believed was "true" scientific medicine.

Elizabeth Blackwell was not an isolated thinker among women physicians. The majority of her female colleagues continued well into the 20th century to offer a morally distinct alternative to the prevailing vision of scientific medicine emerging as a result of the bacteriological revolution. Blackwell's own New York Infirmary for Women and Children, founded in 1854, boasted of one of the earliest outpatient dispensaries, which included home visits to the poor to teach hygiene and preventive medicine. Similar institutions founded by female medical graduates in the 19th century focused on the problems of women and children, and took a strong interest in preventive medicine and public health. My own comparison of male and female therapeutics at two obstetrical hospitals during this period has revealed that, although differences in the mechanics of obstetrical practice were minimal, subtle, but important variations in physician-patient interaction may have made the experience of being treated by

a woman physician a more positive one for the patient. For example, women doctors made rounds more often than men, and prescribed mild supportive therapies while the men did not. The women concerned themselves with their patients' social situations. Many an unmarried mother was settled in a job after she left the hospital, and countless poor patients were kept long after their recovery until proper housing could be found for them. Even today, studies reveal that women physicians often spend more time with their patients and usually take a more thorough history.¹⁶

In the early decades of the 20th century, as the one surviving women's medical college—the Woman's Medical College of Pennsylvania—struggled with mounting debts, it maintained its reputation for training excellent clinicians. Finally, women physicians' participation in social medicine and public health far outweighed their proportion in the profession, a fact which suggests that Blackwellian concerns with holistic approaches continued to be important to them well into the era of of experimental science, technology, and specialization. In their emphasis on patient care, they demonstrated a form of "maternal thinking" which was surely rooted in their separate experience as women. Perhaps their activities stand as historical proof of the existence of "the spiritual element of maternity."

Even as they welcomed the new scientific discoveries, women physicians worried that technology would threaten traditional approaches to patient care. Perhaps some of their fears have come to pass. The triumph of a concept of objective, value-free science has allowed biomedical researchers to divorce themselves from the social uses of their knowledge, ignoring questions of morality. Scientists now are capable of performing a whole range of procedures in the area of reproductive technology and genetic engineering, for example, which have the potential to profoundly and irrevocably alter our environment and the structure of our social institutions. Moreover, researchers generally have left it to the public to monitor the application of this work. Yet, they have rarely troubled themselves to interpret the meaning or implications of their findings in language that the public can readily understand. They have left that task to others less qualified than themselves, and the result too often has been distortion and public misinformation.

In the last decade, critics from within the medical profession have joined forces with the lay public and detractors from a variety of disciplines to decry a "model of disease no longer adequate" to its scientific tasks or social responsibilities. "Medicine's crisis," the psychiatrist George L. Engel has written, "stems from the logical inference that since 'disease' is defined in terms of somatic parameters, physi-

The two houses (on the left) make up the original location of the Women's Medical College of the New York Infirmary; these were located on lower Second Avenue, New York City.



Figure 3. Mural by Josephine Truslow Adams depicting the New York Infirmary and the Women's Medical College of the New York Infirmary. (©Courtesy of the New York Infirmary, Downtown Beekman Hospital.)

cians need not be concerned with psychosocial issues which lie outside medicine's responsibility and authority." Like Elizabeth Blackwell before him, Engel deplores the persistence of a "mind-body dualism" in medical thinking which assumes that the whole can be understood, "both materially and conceptually by reconstituting the parts." Unlike Blackwell, Engel is in a much better position to acknowledge the extraordinary achievements of scientific medicine in the last 100 years. And so he does. But, he warns, these have come mostly at the price of promoting "an approach to disease that neglects the patient." He notes that younger physicians increasingly are forced to confront the contradictions between the "excellence of their biomedical background" and the "weakness of their qualifications . . . essential for good patient care."

Some challenges to contemporary practice have ascribed to the ascendancy of biomedical reductionism a health care system that exhibits such undesirable procedures "as unnecessary hospitalization, overuse of drugs, excessive surgery, and inappropriate utilization of diagnostic tests." Agrees another physician-critic, Dr. Halsted Holman, "While reductionism is a powerful tool for understanding, it also creates profound misunderstanding when unwisely applied. Reductionism is particularly harmful when it neglects the impact of nonbiological circumstances upon biologic processes . . . some medical outcomes are inadequate not because ap-

propriate technical interventions are lacking, but because our conceptual thinking is inadequate." Clearly, what is needed is a biosocial model of disease much like the one women physicians proposed over a century ago. Such a model, while possibly diminishing the authority of the physician, would readmit the patient's subjectivity as legitimate in diagnosis and in healing.¹⁷

A century ago, women physicians practiced in a medical world which rapidly was devaluing subjective forms of knowing, forms which were becoming increasingly identified with the feminine. The bacteriological revolution helped to discredit the "art" of medicine in favor of technological expertise and laboratory experimentation. More and more after 1880, subjectivity would be viewed as counterproductive, even in patient care. These changes had an important effect on the way medicine was organized and practiced. Incorporating biomedical reductionism, medical professionalization eventually engendered a caste system among health care personnel which split off caring from curing. Eventually, medicine became a less congenial profession for women than it had been in the 19th century, and they remained a marginalized minority well into the 1970s.

It appears to me that the cost of that marginalization to medicine itself has been quite dear. First, the exclusion of women from a significant role in shaping 20th century medical professionalization

has meant the loss of a theory of knowing often, though not solely, derived from the primarily female activities of nurturing, generating, and caring. What has been reinforced instead, is a narrow and rigid cognitive stance that has confined subjective forms of knowing increasingly to the realm of art, literature, and the private world of the family. The labeling of subjectivity as feminine, and its consequent devaluation, has banished its effectiveness even for the women who successfully have entered the profession. The supposedly gender-blind concept of scientific objectivity actually has been modeled only on a single, more "masculine" way of knowing—one which rigidly separates subject from object, the knower from the known. This development has distanced patient from practitioner, an outcome particularly problematical because medicine is the most interpersonal of all the sciences.

Two contemporary examples of the dimensions of this loss may serve to illustrate my point. The first merely cites the absence of clinicians capable of treating patients with empathy and humanity. Melvin Konner, an anthropologist who, in his mid-30s, fulfilled a lifetime dream of going to medical school, speaks poignantly in his recent book of one of his first encounters with a caring clinician/teacher:

I did not fully appreciate while I was taking basic clinical skills that I was being exposed to two of the best clinical teachers I would encounter in medical school. One was Ross Weinberger, the internist who was my primary supervisor in most of the patient evaluations. He was a socially awkward man with a beak nose and heavy glasses, and an asthenic, slightly stooped frame. He worked for a community health plan with an excellent reputation and he seemed to have no academic ambitions. His general grasp of internal medicine seemed as good as that of anyone I met before or since, but that was not the point really. He was simply with the patients in a way I would rarely see again. He had a penetrating gaze that was medically critical yet full of convincing practical warmth. . . . He cared, professionally, about the nonmedical aspects of his patients' problems—their characters, their families, their living situations, their incomes. Ignorant as I was, I made the mistake of taking all this for granted. I assumed I had had some bad breaks in certain teaching encounters during the preclinical years, and that now I was embarked on an apprenticeship journey under the command of real doctors. Little did I realize with what longing I would later look back on Dr. Weinberger's simple human decency.¹⁹

My second example of how the concept of scien-

tific objectivity has distanced patient from practitioner has to do with the dynamics of medical decision making between doctor and patient. Two recently published books on informed consent tell strikingly similar stories in their introductions. In his book, *The Silent World of Doctor and Patient*, Dr. Jay Katz recounts the story of a close friend—a university professor—who sought his advice after a surgeon recommended immediate excision of the gallbladder following his friend's first acute attack. The surgeon had not mentioned the possibility of no treatment and watchful waiting as an alternative, although such an option was equally medically sound. Katz suggests a number of reasons for the surgeon's refusal to include the patient in the decision—the belief that patients are incapable of understanding the complexity of diagnosis and treatment, the assumption that patients wish doctors to decide for them, and the fact that long explanations take too much time. But the one that stands out is Katz's suggestion that the surgeon probably believed explanation unnecessary, because doctor and patient shared an identity of interest in medical matters. Such an extraordinary assumption can follow only if, in his own mind, the doctor radically separates the patient from the disease. To treat the whole patient, Katz observes, would have required the surgeon to recognize that "physicians' personal and professional experience and preference may dictate one course; the patients' needs, expectations, and preferences another one." In other words, the physician would have had to consider the patient's subjectivity—including his life outside the hospital room—in the decision-making process.²⁰

In her study of the treatment of female patients, *In the Patient's Best Interest*, the medical sociologist Sue Fisher tells a similar story about herself. After six years of observing the delivery of health care to women in various clinical settings, she too became a patient when a large ovarian mass was discovered during a routine examination. Newly arrived in the community, she was referred by a nurse-practitioner to a gynecologist whom she encountered for the first time while lying on her back with her feet in stirrups. After a brief examination, his nurse ushered her into his consulting room, where Fisher listened as the doctor explained that she needed to be hospitalized as soon as possible for tests, followed by a total hysterectomy. No other information was offered, nor were alternative choices for treatment discussed. When she asked why a hysterectomy must be performed even if the mass was not malignant, her doctor explained that a woman her age no longer needed her uterus or ovaries, since she would soon be going through menopause and could be managed quite successfully on estrogens. In the book, Fisher recalls:

I paid the bill and left the office . . . a lot less confident about my ability to cope during medical interactions. I knew from my previous research that the institutional authority of the doctor's role provided an interactional edge for the physician that placed the patient at a disadvantage. But I had been totally unprepared for how great that disadvantage would be for me—a well-informed professional woman. Somehow, I had assumed my research provided me with an immunity. My field of study is medical interaction. I am armed with the medical knowledge and social skill to interact with medical personnel as a competent person. Yet I fared no better than most of the patients I have studied.

In a visit to a second gynecologist, Fisher had a slightly more positive experience. Although he, too, recommended total hysterectomy on the grounds that she no longer needed her uterus, when pushed, he reluctantly acknowledged that limited surgery also was a medically sound alternative. Each of these stories suggests that meaningful collaboration between physicians and patients has been given short shrift in this age of science, where, Jay Katz reminds us, the expectation is that treatment requires only "silent scalpels, wordless monitors, and mute pharmacological agents."²¹

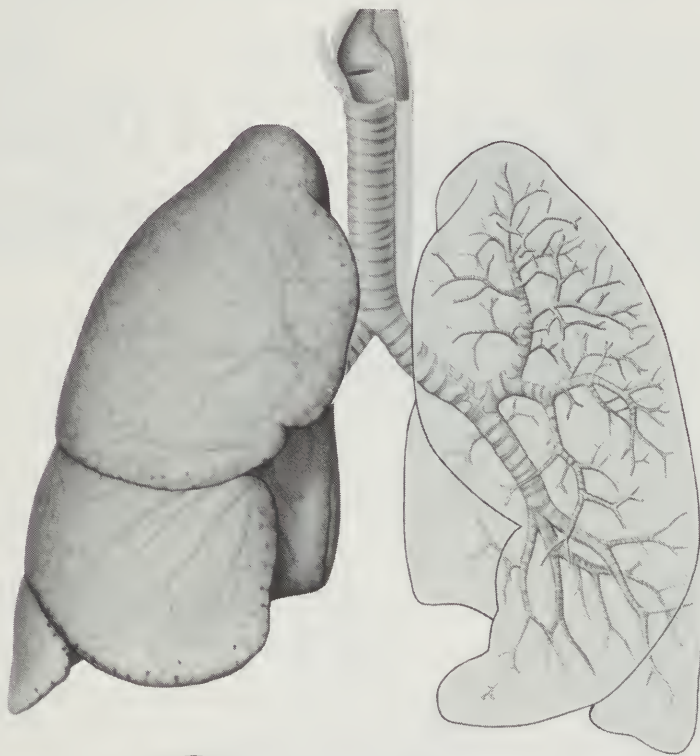
Modern medical practice surely has suffered from these painful and anxiety-ridden encounters between doctor and patient, and public disaffection in the last several years has taken forms too numerous to mention. I suggest that marginalizing women physicians at the beginning of this century may have exacerbated those tensions. In addition, the absence of women has allowed medicine to be organized and

practiced almost exclusively according to the male life cycle. In our culture, such a lifestyle rarely is compatible with having babies or being intimately and integrally involved in their nurture and growth. And yet, many psychologists agree with Eric Erikson that the experience of generativity is an essential stage in the adult maturation process. But, the demanding routine of medical practice, call schedules, and residency requirements, has penalized or completely excluded men and women wishing to participate in a full and satisfying personal life. It goes without saying that such developments have weighed especially heavily on women. But they also effectively have barred the male physician who sincerely believes that a person with family ties, human emotions, and diverse intellectual interests, makes for a more effective healer. My point is not that all women doctors must run out and have babies. Feminists have justly fought long and hard for the right of individual women to choose from a range of lifestyles other than marriage and a family. What I do believe, however, is that the professional ethos which has hitherto shaped medical education and practice must make room for family and personal life. This change will positively affect patient care and minimize present problems in the selection and training of physicians. What the profession needs now is a healthy dose of "the spiritual power of maternity." Accomplishing such a goal would mean, not just the effective reorganization of medical practice, an imminent development in any case, but the revival of a more holistic version of medical science—one which women doctors advocated over a century ago—at a time when few people were prepared to listen. ■

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Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum

human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclo[®] (cefactor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclo have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclo is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclo are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclo. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have

occurred in patients with a history of penicillin allergy. Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[0617B2R]

Note. Ceclo[®] (cefactor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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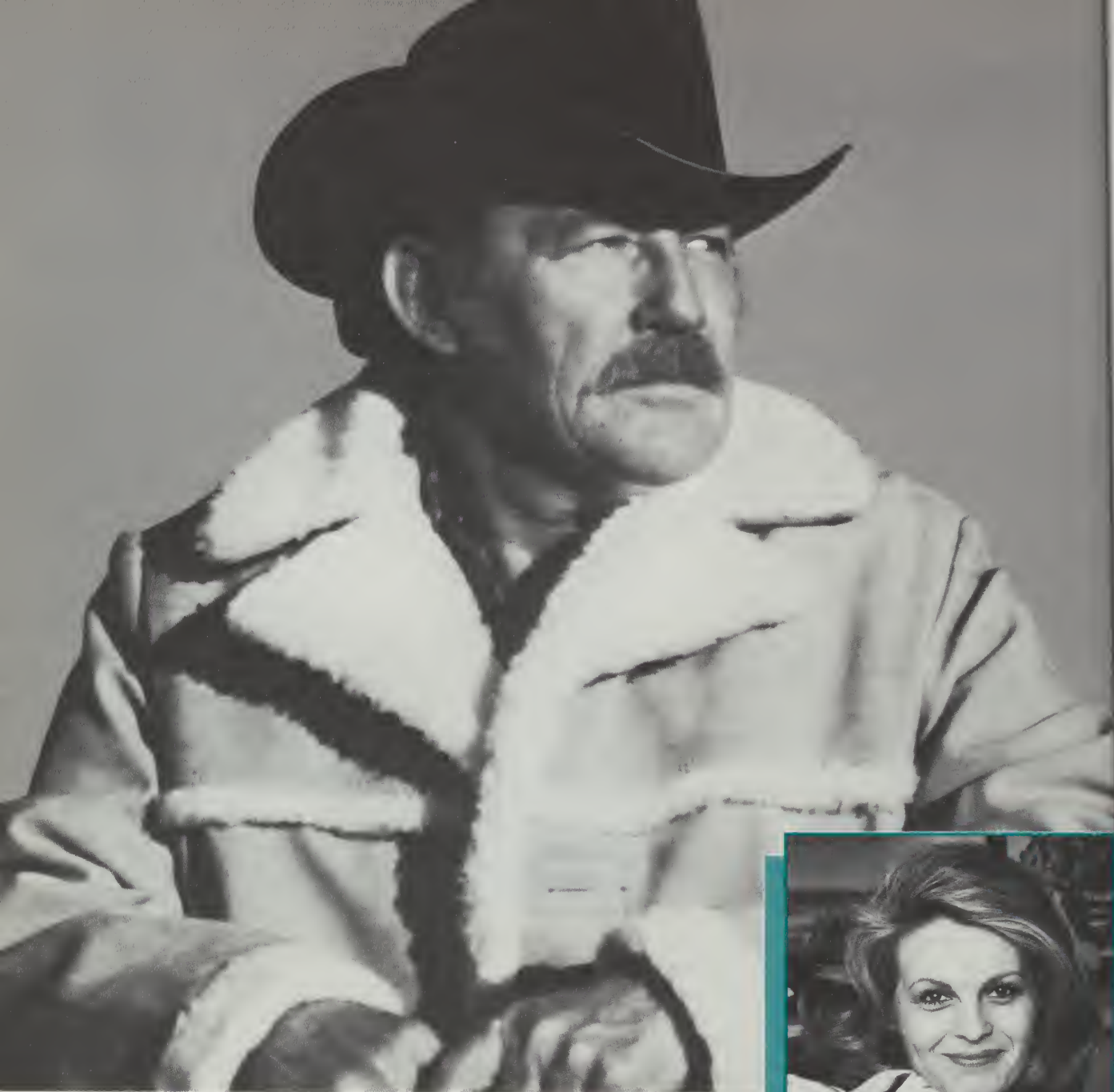
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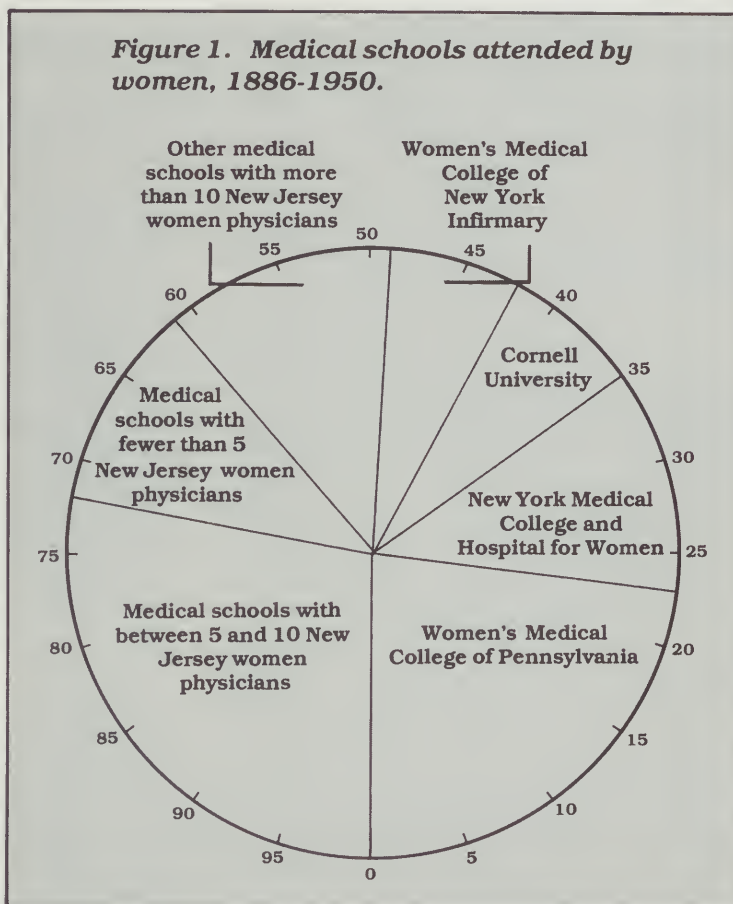
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A Century of Women Physicians

ESTELLE BRODMAN, PhD

Figure 1. Medical schools attended by women, 1886-1950.



The inauguration of the first woman President of the Medical Society of New Jersey, some 200 years after the founding of the Society, brings to the forefront questions about the circumstances of women physicians in New Jersey

over the years. Unfortunately, no complete, fairly standardized compilation of data exists about women physicians in the United States before 1886, when Polk began to publish a directory of all the physicians in the country.¹ Polk's series continued for a number of years; it was joined in 1904 by the American Medical Association's *American Medical Directory*.² As directories are arranged geograph-

ically, it is possible to determine such personal facts as ages, medical schools attended, places of practice, specialties (if any), and retirement dates of New Jersey women physicians.

Some of the questions investigated were: How many wom-

en practiced medicine in New Jersey in the century from 1886 to 1982? Where were they educated?

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Figure 2. Medical schools attended by New Jersey women physicians, 1961.

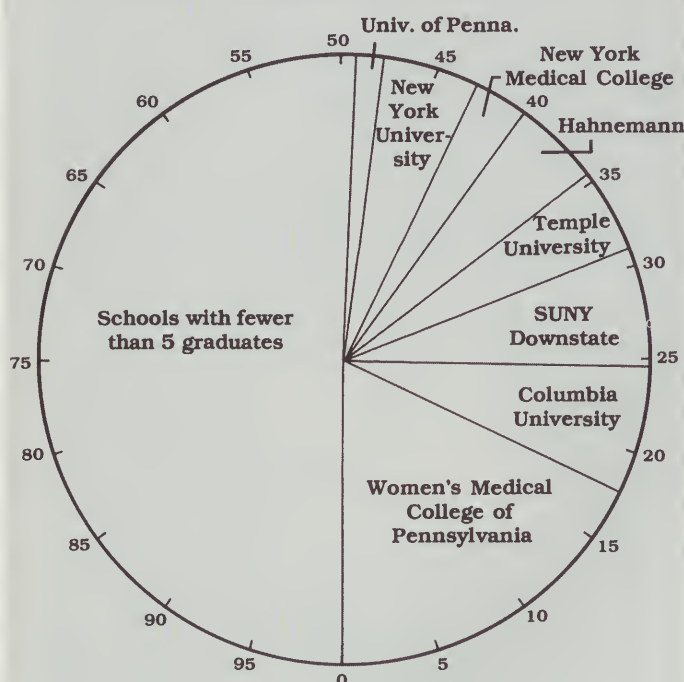
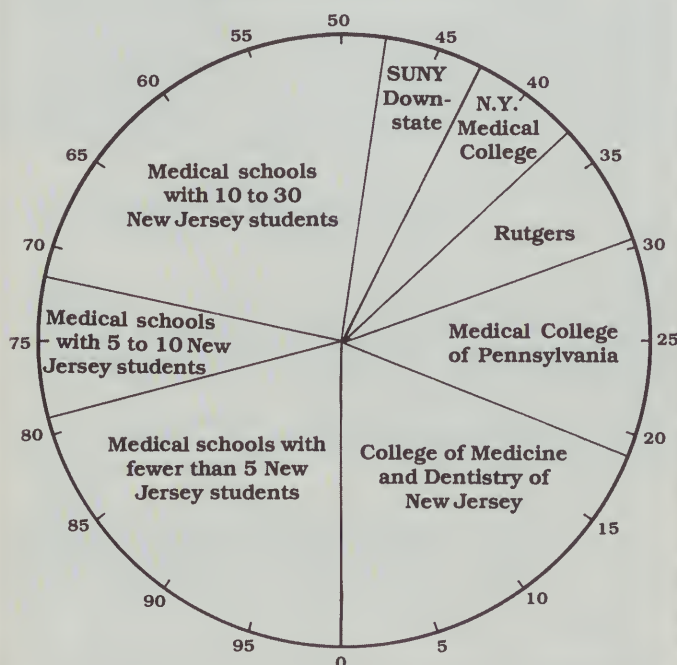


Figure 4. American medical schools attended by New Jersey women physicians, 1982.



Where did they practice? Did they specialize, and if so, in what fields? Was there any indication of their marriage; if so, how did this affect their practice? When did they retire? How did New Jersey statistics compare with the United States as a whole?

METHODOLOGY

To obtain the answers to these questions, it was necessary to compile an index of each woman physician in New Jersey. To read every page of every New Jersey section in all the directories for 100 years would be impossible. It was decided to sample the series by reading and compiling the data in every tenth volume when possible. General data for 1970 already had been collected by a national source; therefore, this material was used. Altogether nine directories were read item by item and the tenth set of data (1970) was obtained from Pennell and Renshaw.³

For each woman as much of the following information as listed was copied: name, and any changes in it over the years; changes in addresses over the years; date of birth or age; medical school attended and year of graduation; places of practice when different from addresses (hospitals or other institutions); special qualifications (national Board approvals, fellowships in professional associations, or faculty status in medical schools); specialties practiced, with indication whether the physician claimed the specialty as primary or secondary; years of directories in which the physician was listed, noting especially claims of "temporary" retirements; and miscellaneous material.

The data (deposited in the Archives of the library of UMDNJ) described accounts for approximately 2,500 women physicians who practiced in New Jersey from 1886 to 1982. The conclusions stated derive from the tables and diagrams appended.*

FINDINGS

The absolute number of women physicians in New Jersey rose from 173 in 1906 to 1,558 in 1982 (Table 1), but there was little variation in the size of the group from 1906 until after World War II, when a large increase occurred. If examined in relation to either the growth in the total population of the state or the number of male physicians, this increase in numbers is not surprising. New Jersey, like most other states, consistently lowered the ratio of physicians to population during the first half of the 20th century. Thus, in 1909, the state had 1 physician for each 1,033 residents; this ratio fell regularly, until 1973 when there was 1 physician for every 426 residents.

World War II also proved to be a watershed for

the ratio of female:male physicians in New Jersey. Before that time, the ratio had varied from 1 female: 12.5 male physicians (in 1906) to 1 female: 28 males (in 1936); but by 1976 this relationship had reversed itself dramatically, showing 1 female: 8.23 males. In this, New Jersey was consistent with the experience of the country as a whole.⁸

Medical Education. Since excellence in medical care is related directly to the medical training received by its practitioners, a study of the medical schools attended by women physicians in New Jersey was undertaken. Tables 2 and 3 and Figures 1 to 4 provide data on the most common medical schools attended at various periods.

In earlier days, women's medical colleges and sectarian schools accounted for much of the education of New Jersey women physicians. As such schools ceased to exist or were absorbed by more "regular" colleges, women medical students went to the standard schools accepting them, e.g. the Women's Medical College of Pennsylvania, which accounted for almost a quarter of all New Jersey women practi-

tioners from 1886 to 1950; the New York Medical College and Hospital for Women which provided another 12 percent; the Women's Medical College of New York Infirmary (later absorbed into Cornell University at the turn of the century) provided 15 percent.

In contrast, by 1961, more than 80 percent of New Jersey women practitioners were graduates of co-educational schools, rather than women's schools. And by 1982, there were no American women's medical colleges still in existence. In spite of this, the Medical College of Pennsylvania could claim to have educated 11 percent of all the New Jersey women physicians practicing in 1982.

The reasons behind the growth and the decline of separate female medical schools in the United States, as well as both the emergence and the decline of sectarian theories of medicine in the 19th century, are well known.^{9,11} The increasing scientific base of medical practice tended to denigrate the sectarian theories of disease causation, while the changing social doctrine of the relationship between the sexes

Figure 5. Most common specialties for women, 1886-1982.

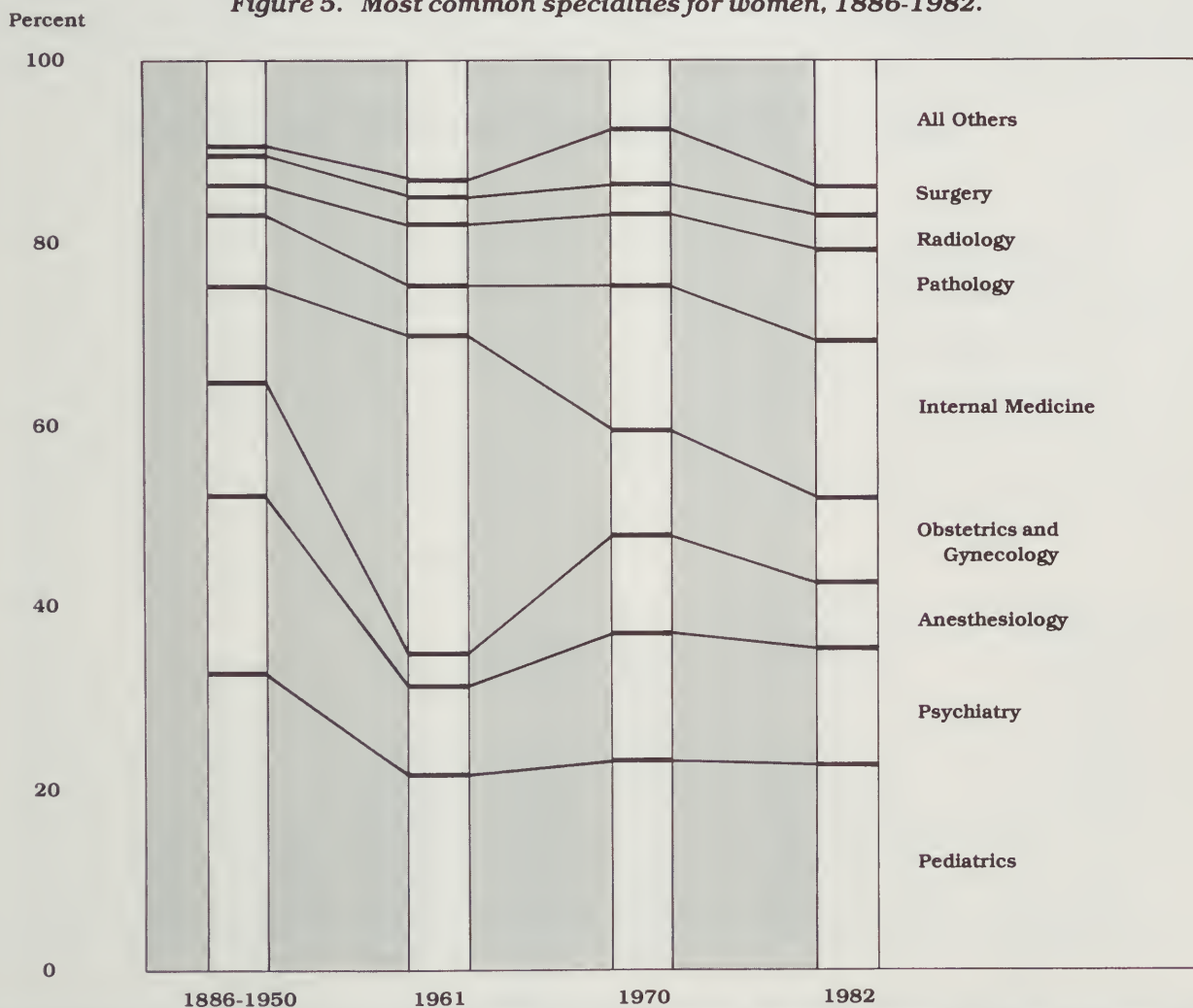


Figure 3. Medical schools attended by New Jersey women physicians, 1982.

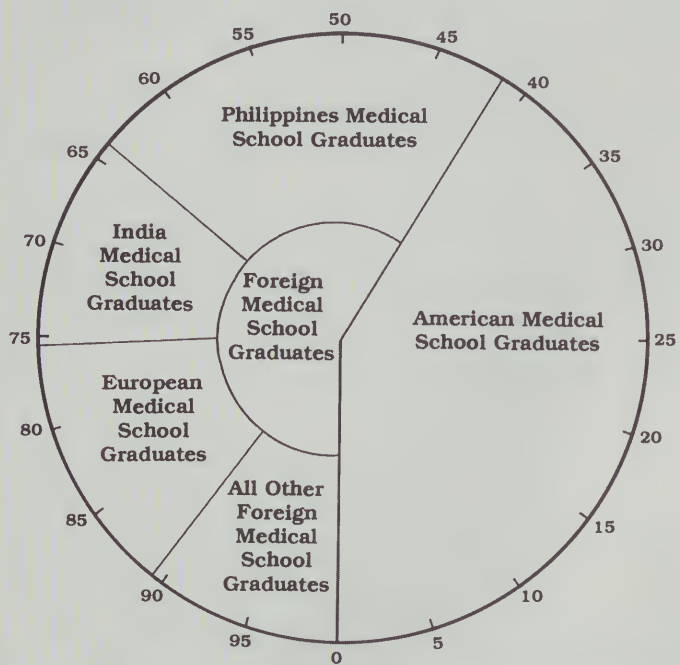
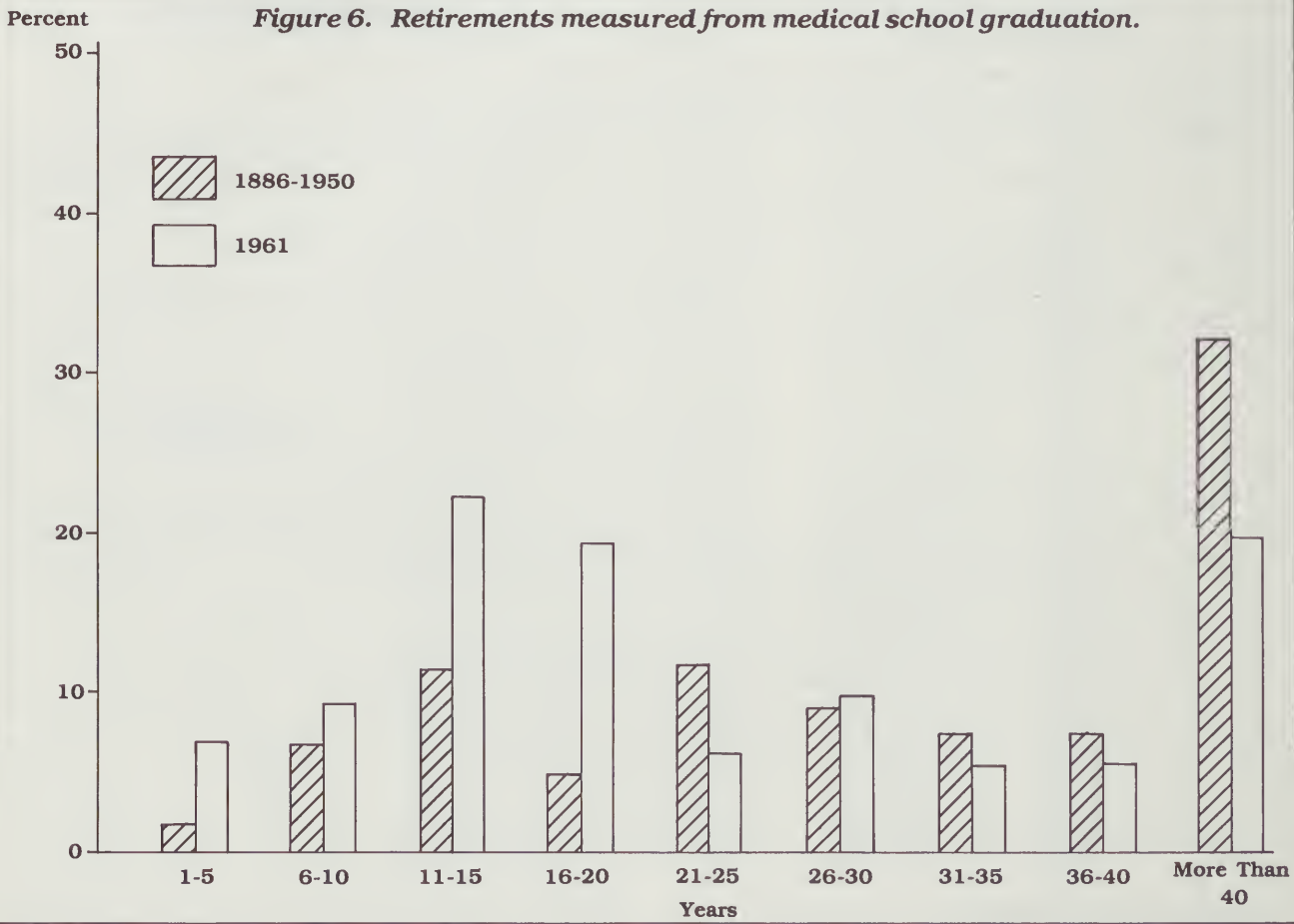


Figure 6. Retirements measured from medical school graduation.



in America led to an increase in coeducation in all fields. As would be expected, New Jersey mirrored the larger national situation.

A further change in educational practice is seen in certification. In earlier days, women physicians often presented both state and national Board qualifications; later, as American Specialty Boards appeared, they were certified by these groups. Yet, female physicians consistently held fewer specialty Board qualifications than male physicians through the 1970s.¹²

Foreign Medical Graduates (FMGs). One of the most profound changes in the composition of New Jersey physicians occurred in the years following World War II. Up to that era, most New Jersey physicians were American-trained or graduated from a comparatively small number of European schools. After that period, the influx of those trained in Asian schools was profound. (In the entire United States, 36 percent of all the initial licenses issued by the State Board of Medical Examiners in 1976 were to foreign medical graduates; however, most of these remained in northeast metropolitan areas, of which New Jersey was one.¹³) It is true the number of European-educated physicians increased as well, but this did not occur so massively as was true of the Asian immigration. As a result of this influx, by 1982 the majority of New Jersey women physicians—almost 57 percent of the total—had been trained in foreign medical schools. Of these countries, the Philippines and India, provided, by far, the bulk of the foreign medical graduates (Table 3 and Figure 3). Not only did these two countries provide more than a third of all New Jersey women practitioners in 1982, but within each country one or two schools accounted for the bulk of those practicing in New Jersey. In the Philippines, for example, no fewer than 56 percent of all the Philippine women physicians practicing within the state in 1982 had graduated from the medical school at Santo Tomas Uni-

versity in Manila. In India, with its total of 114 medical schools accepted by the American Medical Association for licensure, graduates of Bombay University and Gujarat University accounted for 30 percent of all Indian women doctors in New Jersey in 1982. The reasons behind these concentrations are unclear.

The explanation of the overall figures must be sought in international political and economic conditions, as well as in the American rules for licensure of medical practitioners which were in effect from the 1950s to the 1980s. In the Philippines, for example, the increasingly dictatorial government combined with the slippage in economic health in the country, led many educated Philippine citizens to seek their fortunes elsewhere. An attempt for a few years by the Philippine government to prohibit the emigration of its professional class as a national "brain drain" ended in the 1970s, leaving the way open for many to come to the United States. And since the Philippines had been under the domination of the United States for almost half a century, English was the official language of the schools and institutions of higher learning; this rendered it easier for emigrants to succeed in the United States. (This also was true of India.) New Jersey was one of the states favored by the Philippine emigres, because of the clusters of compatriots in such cities as Jersey City, Newark, and Camden.

Another reason for the large number of foreign medical graduates was the need of American medical institutions, especially hospitals and long-term medical care institutions, for residents to handle the day-to-day care of the sick. There appeared to be a shortage of physicians in the 1960s and 1970s, especially in urban areas with concentrations of poor people, and in rural areas. Hospitals particularly were hard hit in their attempts to fill their residency vacancies. The immigration of the FMGs helped solve this problem and, thus, was symbiotic for both

Table 1. New Jersey Physicians, 1906-1982.

Year	Population	Physicians			Ratio of Physicians to Population	Ratio of Female to Male Doctors
		Males	Females	Total		
1906	1,883,609	2,159	173	2,332	1:808	1:12.5
1921	3,155,900	3,067	157	3,260	1:968	1:19.5
1927	3,894,142	3,615	140	3,755	1:1,037	1:25.8
1931	4,041,334	4,201	156	4,357	1:928	1:26.9
1936	4,080,871	5,177	177	5,354	1:762	1:28.5
1970*	7,171,112		1,137		1:426	
1976*		10,024	1,218	11,242		1:8.23
1982*	7,638,252	11,985	1,558	13,543	1:564	1:7.7

*Estimated from references.

Table 2. Rank Order of American Medical Schools Attended by New Jersey Women Physicians.

School	Rank Order		
	1886-1950	1961	1982
Medical College of Pennsylvania*	1	1	1
New York Medical College	13	5	2
SUNY Downstate	13	2	3
Columbia University	5	2	4
New York University	11	5	5
Temple University	6	3	6
Cornell University	3	7	7
Hahnemann Medical College	14	4	8
University of Pennsylvania	8	6	9
Boston University	13	9	10

Rank Order Correlation

Correlation Between 1886-1950 and 1961 = -5.52.

Correlation Between 1886-1950 and 1982 = -1.11.

Correlation Between 1961 and 1982 = +.70.

*Formerly Women's Medical College of Pennsylvania.

Americans and foreigners alike.

As a result of this situation, a number of other steps were taken by many states, and some were promoted by national medical groups. Some states—such as Missouri and South Dakota—established new medical schools in the hope of furnishing more physicians for rural areas. New Jersey also opened its first medical school during this period, and its success was shown by the fact that by 1982 it was furnishing 19 percent of all women physicians in the state.

Finally, the economic prosperity of the United States in the 1960s and 1970s made it a magnet for those seeking a better life.

Where Women Practiced. The final step taken by many licensure boards required FMGs who wished to practice in the United States to spend at least one year as a resident in a U.S. hospital under the supervision of an American physician. (The Health Professions Educational Assistance Act of 1976 reduced greatly the number of foreign medical graduates training or working in the United States.) An examination of the records of New Jersey women physicians in 1982 shows a large number of them working as house officers in New Jersey hospitals; it will be interesting to compare these records with those for later years to see how many of them remained as regular practitioners in the state.

Throughout the period studied, the vast majority of the women practiced in metropolitan areas, where there was a large population to draw on for patients, and the support of other (often women) physicians was available.

It is said that women physicians often opted for institutional or academic practice, rather than pri-

vate practice, because of its economic reliability and regular hours, allowing women to continue their home and family life. Academic medicine appears to have been chosen by some women for this purpose, even though women seem to be discriminated against in such a setting.¹² In 1972, salaries and retainer fees were the source of income for 31.4 percent of the women physicians, as opposed to 41.7 percent of male physicians.¹⁴

Specialties Practiced. The very earliest 20th century women practitioners in New Jersey rarely reported a specialization; when they did list a specialty, it was likely to be pediatrics, obstetrics, (including gynecology), psychiatry, or anesthesiology. These were "women's specialties" from 1886 to 1982 (Table 4; Figure 5). And, as Pennell and Showell have shown, these specialties were the least well-remunerated of all.³ Not only did the women tend to choose the least well-paid of the specialties, but male physicians in the same specialties garnered incomes 20 percent higher on the average than their female colleagues.

Foreign medical graduates fared even worse than American women physicians. As Rosenthal and Eaton pointed out in 1982, "Female medical graduates occupy a position midway between male medical graduates and foreign medical graduates, and may be pressured to assume some of the FMGs lower-status roles as the number of FMGs decreases."^{14,15}

Retirement. One of the most telling arguments against the admission of women to medical schools had been the belief that women physicians would drop out of the profession earlier than would male physicians, thus wasting the time, energy, and money invested in education. A number of studies

have been offered to show this belief to be erroneous; on the whole, women practice medicine for 32.6 years after graduation, and men 35.8 years.¹⁶

The data collected on retirements for all New Jersey women practicing from 1886 to 1961 are reported in Table 5 and in Figure 6, and show that in the pre-1950 years, retirement did not occur for the majority until 40 years after graduation. In the 1961 cohort, there was a temporary increase in retirements from 11 to 15 years after graduation, but many of these retirees appear to have returned to practice (presumably after their children had grown)

and once again, the most common retirements occurred more than 40 years after starting practice.

CONCLUSIONS

This study of approximately 2,500 women physicians practicing in New Jersey from 1886 through 1982 shows that the patterns in this state were similar to those in the United States as a whole. In the early days, medical school education tended to be in women's or sectarian schools, but later it was in whatever "regular" school would accept women.

Early women physicians offered state and national examination credentials; later physicians had

Table 3. Foreign Medical Graduates, 1982.

Region	Number	Percent*	Cumulative Percent of Country Graduates
Africa	20	2.4	2.4
Asia	520	63.5	65.9
India	156	30.0	
Philippines	318	61.2	
All Other Asian Graduates	46	8.8	
Caribbean	31	3.8	69.7
Europe	180	22.0	91.7
Canada and Mexico	26	3.2	94.9
South America	37	4.5	99.4

*Cumulative percent is 99.4.

Table 4. Most Commonly Practiced Specialties, 1886-1982.

Specialty	1886-1950		1961		1970		1982	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Anesthesiology	18	11.4	7	3.7	64	10.2	100	6.4
Internal Medicine	12	7.6	10	5.2	90	14.3	274	17.6
Obstetrics and Gynecology	16	10.1	60	31.4	73	11.6	135	8.7
Clinical Pathology, Forensic Pathology, Neuropathology	5	3.2	12	6.3	49	7.8	67	9.3
Pediatrics*	48	30.4	42	22.0	149	23.7	354	22.7
Psychiatry**	30	19.0	19	9.9	83	13.2	198	12.7
Diagnostic Radiology and Therapeutic Radiology	4	2.5	4	2.1	15	2.4	52	3.3
Surgery, Orthopedic Surgery, Plastic Surgery	2	1.3	3	1.6	31	4.9	39	2.5
Others	23	14.6	34	17.8	76	12.1	339	21.8
Total	158		191		630		1,558	

Correlations

1886-1950 vs 1961	71.4%	1961 vs 1970	69.0%
1886-1950 vs 1970	81.0%	1961 vs 1982	69.0%
1886-1950 vs 1982	71.4%	1970 vs 1982	90.5%

*Pediatric allergy, pediatric cardiology, pediatric hematology and oncology, pediatric nephrology, pediatric radiology, and pediatric surgery.

**Child psychiatry, psychoanalysis, and psychosomatic medicine.

Table 5. Retirements Measured from Medical School Graduation.

Years Since Graduation	1886-1950		1961	
	No.	Percent	No.	Percent
1 to 5	2	1.6	2	6.7
6 to 10	10	8.0	3	10.0
11 to 15	16	12.8	7	23.3
16 to 20	7	5.6	3	10.0
21 to 25	16	12.8	2	6.7
26 to 30	12	9.6	3	10.0
31 to 35	11	8.8	2	6.7
36 to 40	11	8.8	2	6.7
Over 40	40	32.0	6	20.0
Total	125	101.2	30	100.1

American Board certifications, but not in the numbers offered by males.

These early women doctors tended to be general practitioners; later physicians specialized in "women's specialties" which paid poorly; moreover, they received less income from these specialties than male physicians in the same areas. For a number of reasons, foreign medical graduates came in great numbers in the 1970s and 1980s, mostly from the Philippines and India, and they often acted as hospital house staffs or worked in hospital-based special-

ties, with minimum recompense. Indeed, a somewhat larger proportion of women—American trained or FMG—than men physicians had hospital-based practices.

Because of their family needs, New Jersey women physicians often opted for specialties with regular hours, and sometimes ceased practice temporarily while their children were young. In spite of this, however, the final retirement figures for women physicians in New Jersey were not very different from those for male physicians. ■

**Names.* The difficulties in distinguishing between male and female names should not be overlooked, because many names are used for males and females or are family names with no indication of sex. *Foreign names.* The enormous increase of foreign medical graduates in the 1970s and 1980s makes it difficult for someone not knowledgeable in the various languages to determine the sex of the individuals listed. Where the given name was known to be female, or where the listing of another physician at the same address—apparently a spouse—was encountered, it was decided that the name was female. If the individual specialized in one of the more common female specialties, it was taken as further

proof. If the individual was a graduate of a female medical school (e.g. Lady Harding Medical College for Women in Delhi), it was assumed that the name represented a woman. *Inconsistency of published data.* The two sets of directories used do not provide the same information about those listed. For example, the birth dates are included in early directories, but not in later ones; similarly, the year of graduation from medical school is found only in lists before the 1970s. This dearth made difficult, if not impossible, the comparison of length of practice before retirement. In addition, specialties were described with different terms at different times, further confusing the comparisons sought over time.

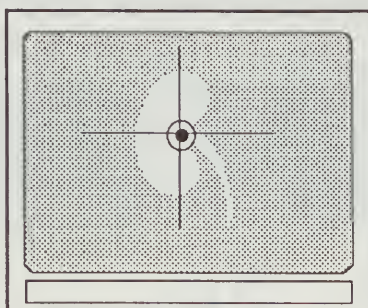
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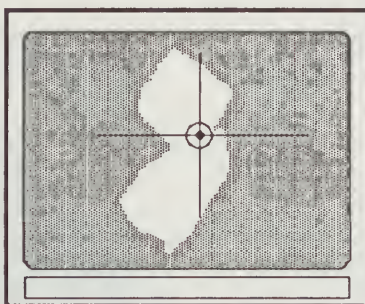
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New Jersey Medical Women's Association

SUZANNE A. WIDROW, MD
CHRISTINE E. HAYCOCK, MD



The New Jersey Medical Women's Association (NJMWA) was born in Atlantic City on June 16, 1924. It was conceived by Dr. Clara DeHart Krans (1873-1952) of Plainfield, with the "idea of promoting friendship" among women physicians of the state. It is not recorded in the minutes of the first meeting how many women were present, but it soon became evident that these physicians were anxious to do more than lunch together.¹ Dr. Krans was an active member of the group and worked to help women become accepted as interns in New Jersey hospitals. In 1927, the NJMWA became Branch Four of the American Medical Women's Association (AMWA).

The national organization, AMWA, came into existence in 1915. It was organized by Bertha Van Hoosen, MD, of Chicago, to coordinate the numerous women's medical associations which had formed throughout the country to help women physicians obtain a forum for the exchange of medical information and the maintenance of skills, since they were excluded from membership in the American Medical Association (AMA) and many other medical societies. In 1915, the AMA did begin to accept women as members, and other medical organizations slowly followed suit.²

In 1931, at the suggestion of Mabel Haines, MD (1883-1964), the Clara Krans Research Fund was started by several members of the NJMWA. Carye-Belle Henle, MD (1899-1977), New Jersey's first woman radiologist and the first woman president of the Radiological Society of New Jersey in 1959, became the guardian of this fund. Upon her death, the fund was renamed the Krans/Henle Memorial Fund.

This fund is supported by donations, legacies, and 10 percent of the NJMWA treasury every year. Eighty-five percent of the interest earned is given in the form of outright grants to outstanding women medical students from New Jersey.

There has been a number of extraordinary women physicians in New Jersey during the past 100 years.^{3,6} Although many outstanding women physicians have been members of NJMWA since its inception 64 years ago, it is possible to mention only a few of those women who have worked to advance the status of their sister physicians and of medical practice in New Jersey:

★ **Ellen Potter, MD (1871-1958)** was one of the most prominent early women physicians in New Jersey. She served successfully as director of the medical department of the North Jersey Training School for Feeble-Minded Females at Totowa, then superintendent of the Clinton Reformatory for Women, and the State Home for Girls in Trenton. She was president of Woman's Medical College of Pennsylvania in 1941, and in 1946 formulated the state regulations governing adoption in New Jersey. She served as national president of AMWA in 1929 and was honored by NJMWA as "Woman of the Year" in 1954.³

**Suzanne Allen Widrow, MD, and Christine E. Haycock, MD, are past-presidents of the New Jersey Medical Women's Association. Dr. Haycock is a past-president of the American Medical Women's Association. Requests for reprints can be addressed to Dr. Widrow, 213 River Road, East Hanover, NJ 07936.*

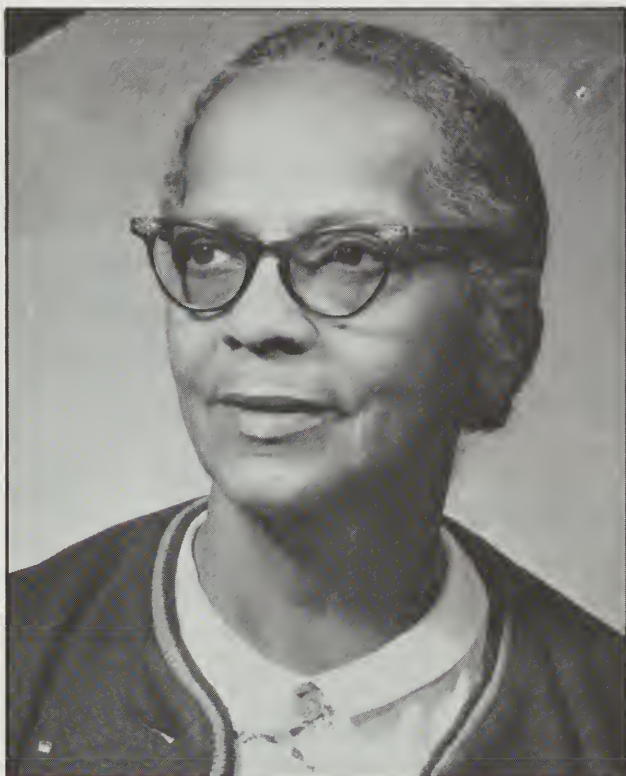


Figure 1. Lena Edwards, MD, as a member of the Hudson County Medical Society.

★ **Stella Bradford, MD (1871-1959)** was director of physical medicine at The Mountainside Hospital from 1932 until 1953. She established the first visiting nurse service in Montclair and the first fresh air school and tuberculosis clinic.³

★ **Vera Schectman, MD (1884-1971)** became the first woman physician on the staff of Newark Beth Israel Medical Center; she outraged some of her friends and colleagues in 1916 by giving lectures on sex education.

★ **Louise Pearce Skillman, MD (1885-1950)** led an expedition through the jungles of Africa and helped develop the drug, tryparsamide, in 1915 for African sleeping sickness. She served twice as president of AMWA.

★ **Rita S. Finkler, MD (1888-1968)** established and headed the first department of endocrinology in New Jersey at Newark Beth Israel Medical Center, and published over 70 papers in the field of endocrinology during the 55 years she practiced in Newark.

★ **Mildred Gregory, MD (1884-1975)** served as medical director of Babies Hospital in Newark from 1949 to 1957, and was one of the first women diplomates of the American Board of Pediatrics.

★ **Jeannette Munro, MD (1894-1986)** was Princeton's first woman pediatrician, and practiced in Mercer County from 1933 to 1965.³

★ **E. Mae McCarroll, MD (b. 1898)** practiced in



Figure 2. Anita Falla, MD, as inaugurated as a member of the MSNJ in 1960 and board certified in 1961.

Newark for 48 years. She led a Newark crusade to stamp out venereal disease, and became the first black physician to be appointed to the staff of Newark City Hospital in 1946. She was named Deputy Health Officer of the city of Newark. Dr. McCarroll was active for over 16 years with the National Medical Association and helped establish its journal. She was honored in 1973 as the First Lady of the National Medical Association.³

★ **Anne Lardner Moore Shannon, MD (1898-1960)** became the first woman physician on the staffs of The Mountainside Hospital and Montclair Hospital, and the only woman surgeon on these staffs.³

★ **Eva Brodtkin, MD (b. 1899)** became the first woman intern at Muhlenberg Hospital, and in 1931, New Jersey's first woman dermatologist. She was president of the New Jersey Dermatological Society and chief of the Dermatology Service at Saint Barnabas Medical Center for many years.³

★ **Jessie D. Read, MD (1903-1979)** was a founding fellow of the American College of Obstetrics and Gynecology. She was one of the first women physicians commissioned in the army from New Jersey in World War II and served as chief of surgery of a hospital unit in Europe.⁵

★ **Mary Bacon, MD (1893-1971)** of Bridgeton was president of Cumberland County Medical Society.



Figure 3. Zelda M. Marks Rosenthal, MD, received the Elizabeth Blackwell award for service in 1980.



Figure 4. In 1961, Christine E. Haycock, MD, became the first board certified woman surgical specialist in New Jersey.

★ **Lena Edwards, MD (1900-1987)** had a long medical career in Jersey City, and despite the disad-

vantage of being both black and female, achieved many honors.

★ **Camille Mermod, MD (1901-1976)** was president of AMWA, in 1954 and 1956, and edited the journal of the association for many years. She was awarded the Elizabeth Blackwell medal in 1965, AMWA's highest award. In 1969, AMWA announced a new award in her honor, which is presented annually to the lay person who has rendered outstanding service to the organization.³

★ **Laura E. Morrow, MD (b. 1913)** was president of AMWA in 1969 and was awarded its Elizabeth Blackwell medal in 1974. She was the first woman president of the Passaic County Medical Society in 1972, and was president of the Society of Clinical Psychiatrists of Northern New Jersey in 1965.³

★ **Anita Falla, MD (b. 1921)** and **Christine Haycock, MD (b. 1924)** were the first women to be board certified surgical specialists in the state in 1961, and Dr. Falla was subsequently elected president of the New Jersey chapter of the American College of Surgeons in 1986.

NJMWA has established county-based units for local meetings, journal clubs, leadership role models, and mentors for medical students and liaisons with these student branches. The organization offers scientific meetings with distinguished speakers held at members' homes, and joint meetings throughout the year with the New Jersey Women Lawyers Association.

Fundraising affairs are held to benefit the Krans-Henle Scholarship Fund and yearly awards are given to deserving medical students. A quarterly newsletter is published and sent to members. There are regional meetings jointly sponsored with the New York branches.

NJMWA is closely involved in the AMWA national programs to prevent cigarette smoking in teenage girls, which is one of the most distressing medical problems in women today. The organization is involved actively with AMWA in furthering the leadership abilities of our members and helping to overcome the under-representation of women in leadership positions in American medical organizations. With the inauguration of Dr. Formica, AMWA hopes young women physicians will become actively involved in organized medicine as a means of effecting change. ■

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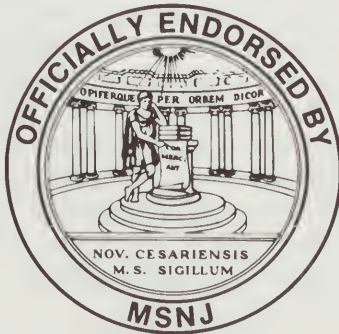
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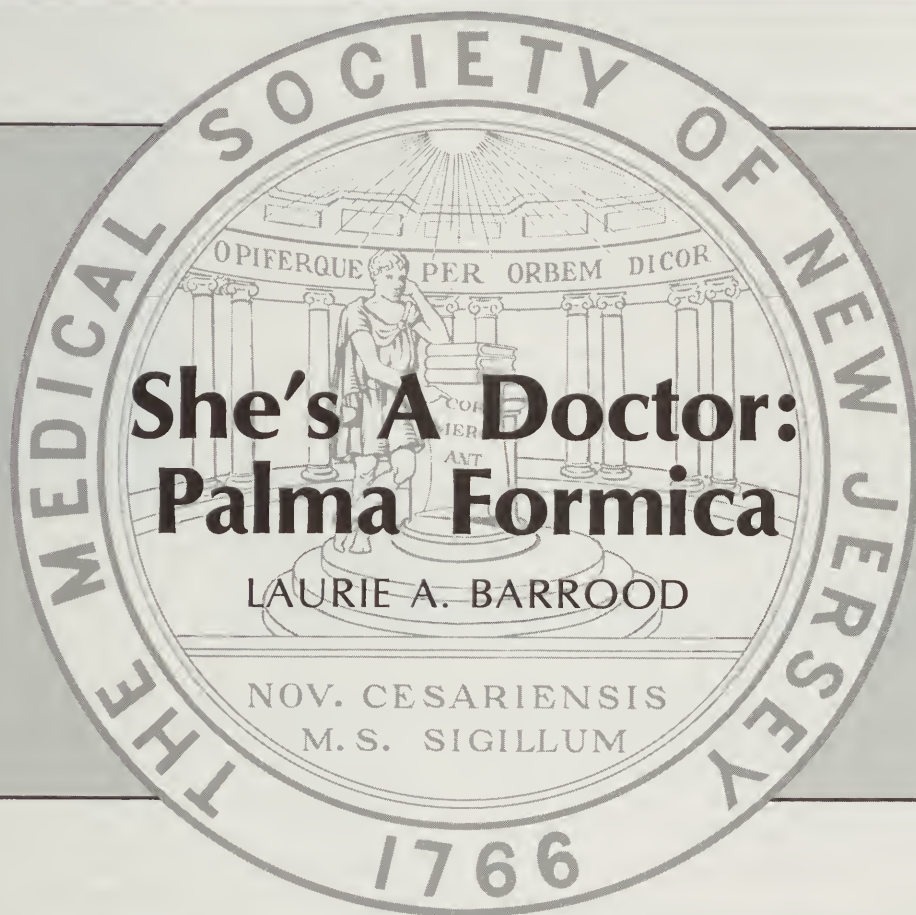
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She's A Doctor: Palma Formica

LAURIE A. BARROOD

Salvatore Formica said to his daughter, Palma, "Whatever you want to be, you can be, because you're in America." That was the legacy that helped shape his daughter's future. An immigrant from Sicily, Salvatore worked hard in the local steel mills, determined to provide his family with all the necessities, especially education. He wanted to give his children all the education they could take.

As a child with scarlet fever, Palma Elizabeth Formica remembers the doctor who stayed with her and nursed her back to health. "From that time, I knew I wanted to be a doctor. I didn't know any women physicians, but there was never any doubt in my mind that women could be doctors; plus my parents backed me," she said.

"In those days we were very poor. I had one dress that my Mom would wash for me every night. I was the poor kid with big dreams." How could she know that one day, she would make history.

Palma Formica, MD, is not only the 196th President of the Medical Society of New Jersey, she also is the first woman president of the oldest medical society in the country. It is something she never dreamed would happen, even as she went through the steps.

Palma graduated from Pennsylvania's Johnstown Catholic High School, in 1946, and she completed

a Bachelor of Science degree at the University of Pittsburgh, in two and a half years by going summers as well as winters.

Palma attended medical school in Rome, partly because it was inexpensive. "Money wasn't the only reason, my relatives were there, too. Living in Italy gave me an appreciation of where my roots were," she said.

After graduating in November 1953, she began a rotating internship in internal medicine at Queens Hospital Center, Jamaica, New York. During the last year of an 18-month residency in internal medicine, she married John J. Rihacek and bore her first son, Tad. Unable to continue the hectic pace of residency and pay for child care, she interrupted her training and had son Gregory the next year.

In 1958, Dr. Formica and her family moved to Old Bridge where she opened a family practice. After her third child Alycia was born, she slowly became active in the community and in her church. She joined the Middlesex County Medical Society, the Medical Society of New Jersey, and the AMA; and she became the local fire department and school board

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physician for her community.

Dr. Formica loved being a family physician. It was all she had always imagined. More importantly, her real satisfaction was being part of the families she cared for. "No amount of money could ever replace the relationships between me and my patients," she said.

Dr. Formica didn't have the large practice she could have; she felt it was important to be involved in school and church activities as well as in the community, while her children were growing up. "Spending time with my family was very important to me, and I also felt I had a commitment in the community," she said.

The extent of her involvement in the Middlesex County Medical Society was strictly membership. She didn't become actively involved until 1975. She remembers making a comment to one of her colleagues on the Society's nominating committee saying, "The Middlesex Medical Society was nothing but a bunch of old, chauvinistic men. Shortly after my comment, he offered me the position of secretary and bulletin editor. I tried to refuse, knowing I was too busy, but he said, 'Pam, put up or shut up!'"

She became president of the Society in 1977, which resulted in a heavier involvement in the Medical Society of New Jersey, and her upward climb through its ranks.

During that same period, Dr. Formica became more involved in the Department of Family Medicine at St. Peter's Medical Center in New Brunswick. In 1979, she became senior attending and chairman of the Department.

After the death of her husband, Dr. Formica was asked by Dr. Frank Snope and Dr. Joseph Lieberman from the University of Medicine and Dentistry of New Jersey (UMDNJ), to help form a Family Practice Residency Program at St. Peter's for UMDNJ-Robert Wood Johnson Medical School (formerly Rutgers Medical School). She was very flattered about the offer because she never really imagined herself as an academician. It was a huge leap for her from a private practice to a teaching position; but working with students would give her an opportunity to pass on her valuable knowledge.

"I was disturbed by the lack of emphasis placed on the art of medicine for medical students. It seemed to me that the students were losing the 'caring' aspect of medicine," said the doctor. "I wanted to give them a legacy of values I felt were important."

She eventually brought her private practice to St. Peter's and used it in conjunction with the new residency program. "Everything fell together." Although this was not one of her long-term goals, the surrounding circumstances had molded things.

Asked what her position as associate professor of Clinical Family Medicine at UMDNJ-Robert Wood Johnson Medical School means to her, Dr. Formica says it means an 'extension of service' which has guided her through life. "It is a different type (of service) but it is still rendering service to patients and other people," she said. "I am helping to mold attitudes and feelings, I am able to touch lives and value systems. I have great hopes for the future of medicine."

Dr. Palma Formica is not afraid of the road ahead. "I see in young people dedication, ethics, and a desire to provide service. If they do not yield to pessimism, they will find satisfaction and be able to help people live better."

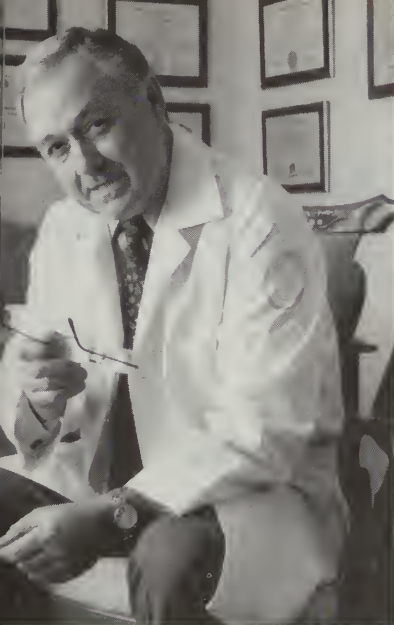
She explained that a general perception about doctors today is that they are in a low ebb in a medical profession hounded by corporations. "I don't see medical professionals as being in a locked step. As long as there is intellectual freedom, the ability to strive, and true dedication, we'll be right there—and not in the hands of the business world."

Dr. Formica attributes her presidency of the Medical Society to the culmination of events that she worked hard to achieve.

"It gives me a great sense of pride to be the first woman president of the oldest medical society in the country," she said. "It's not that I tried to be the first woman of this or that. It just happened." Being the "first woman" places a great burden on her. "It's hard to say no," she explains, "because it sets the pace for other women. I try to encourage women to get involved and stay involved. We are equally as competent as men and we can bring a different perspective to things. There's no magic. Just hard work and some good luck. Women owe it to each other to show that we can run, and we can lose, and still not be losers! We are capable of handling defeat without losing our ideals."

Dr. Palma Formica's entire career reflects her dedication to family, patients, students, and community. A few of her more notable awards have been the Don Quixote Award for Physician of the Year in New Jersey Living Magazine, 1985; the Pope John Paul II, Benemerenti Medal in 1986; and the Edward J. Ill Distinguished Physician's Award from the Academy of Medicine of New Jersey in 1986.

"All of my awards caught me off guard. I'm not trying to be falsely humble, but I've done what I wanted to do with my life! I'm honored that my colleagues thought I deserved to be recognized. I'm lucky to have been able to do all the things I've accomplished. I'm grateful to so many people who have helped me, however, I'm where I am today because of the sacrifices of my parents. They gave me the opportunity to fulfill my dreams." ■



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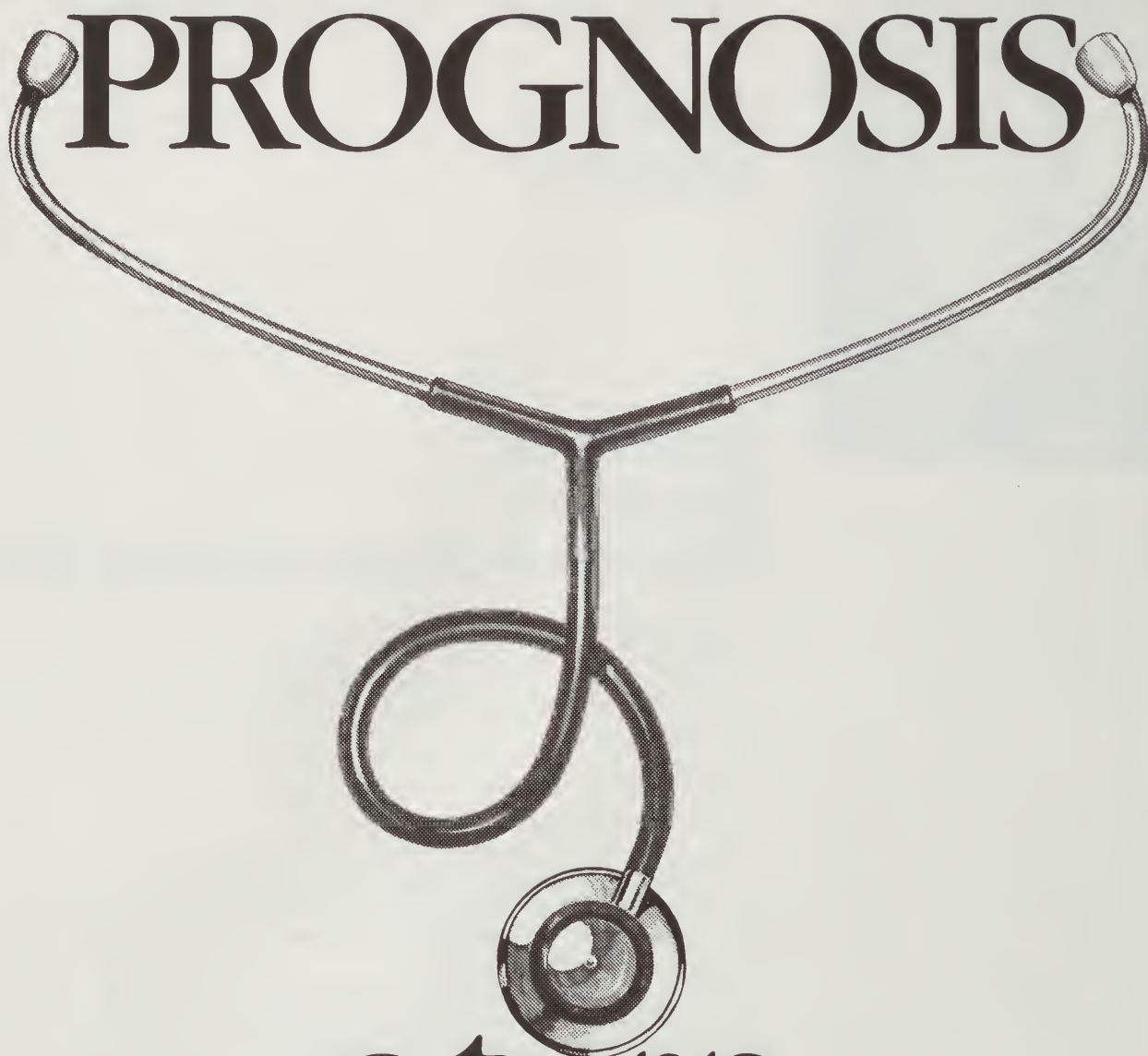
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A Day in the Life

STAN GODLEWSKI



Figure 1. Dr. Formica and Dr. Tom Naughton after a morning meeting at UMDNJ—9:00 A.M.

(© Stan Godlewski)



Figure 2. Dr. Formica viewing x-rays at St. Peter's Medical Center—9:45 A.M.

(© Stan Godlewski)



Figure 3. Dr. Formica chats with Dr. Steve Deak and Dr. Morton Goldstein at St. Peter's Medical Center—10 A.M.

(© Stan Godlewski)



Figure 4. Dr. Formica checks patient Marie Morrison in the intensive care unit—10:30 A.M.

(© Stan Godlewski)



Figure 5. Dr. Formica checks a chart in the files room at St. Peter's Medical Center—11:15 A.M.

(© Stan Godlewski)



Figure 6. Dr. Formica walking a corridor at St. Peter's Medical Center—1:00 P.M.

(© Stan Godlewski)



Figure 7. Dr. Formica and Katie Olshefski reviewing patient files in the Utilization Office at the hospital—2:15 P.M.

(© Stan Godlewski)



Figure 8. Dr. Formica checks the mailbox outside her family practice in Old Bridge—3:30 P.M.
(© Stan Godlewski)



Figure 9. Dr. Formica at home holding her beeper; before long she will be returning to St. Peter's Medical Center to check a patient—8:00 P.M.
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Women in Academic Medicine

ELIZABETH ALGER, MD
LAURIE A. BARROOD

It begins in medical school—the path to becoming a clinician, teacher, researcher, or administrator. As more women pursue medical careers, more are choosing and being chosen for positions of responsibility within the profession. And as women assume leadership roles, students have a diversity of models and mentors that their predecessors lacked.

What prompts women to go into academic medicine?

The answers to this question are diverse. Some like the flexibility, variety, and professional security that it offers. “Academia is the best of both worlds,” says Deborah Rosa, MD, a third-year surgical resident at UMDNJ–New Jersey Medical School.

Other physicians like the fact that academic medicine is not profit-driven, and find working with students and residents very rewarding.

A university’s supportive and creative environment provides professors with the opportunity to learn from colleagues. “Collegiality and the ability to share ideas and to discuss projects are just some of the advantages of being in academics,” says Betty Hammond, MD, an assistant professor in the Department of Family Medicine at UMDNJ–Robert Wood Johnson Medical School.

“The tradition of passing on knowledge and dealing with young people is very stimulating,” says Palma Formica, MD, newly elected president of the Medical Society of New Jersey and associate professor of Clinical Family Medicine at UMDNJ–Robert Wood Johnson Medical School. “I was disturbed by the lack of emphasis on the art of medicine being taught to students in medical school. It seemed like they were losing the caring aspect of medicine. I wanted to leave a legacy of values with them that I felt was important.”

“It is exciting to teach future practitioners what you’re doing. And having projects for them to participate in, makes learning exciting,” says Audrey Gotsch, DPH, associate professor and chief, Division of Consumer Health Education in the Department of Environmental and Community Medicine

at UMDNJ–Robert Wood Johnson Medical School.

A number of faculty members observe that teaching provides a stimulus to their own learning. “Students are enormously challenging because they may

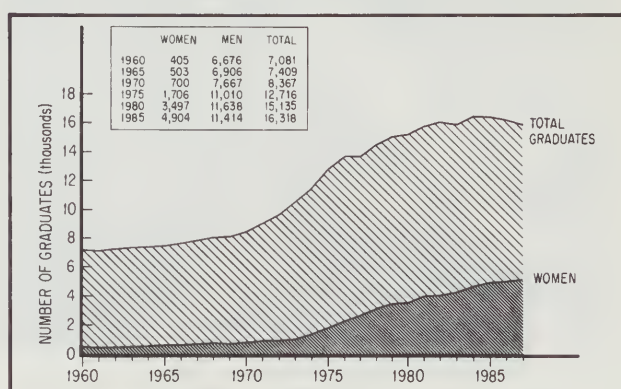


Table. U.S. medical school graduates, 1960 to 1987, noting women and men graduates.

ask questions that require you to do research for an answer,” says Nancy Gary, MD, professor of medicine and executive associate dean at UMDNJ–Robert Wood Johnson Medical School.

Flexibility and research facilities are attractive qualities in academic medicine. Research provides indepth solutions to medical problems, in addition to publishing and advancement opportunities.

Patient care activities are very important components of academic medicine. The opportunity for physicians to practice and demonstrate clinical medicine is the essence of an academic medical center. The clinical facilities at UMDNJ provide patient care settings from primary care to highly sophisticated tertiary care.

Dr. Alger is Associate Dean for Education, UMDNJ–New Jersey Medical School, and Ms. Barrood is Senior News Service Assistant, UMDNJ, Office of Government and Public Affairs. Requests for reprints can be addressed to Ms. Barrood, UMDNJ, Administrative Complex, 30 Bergen Street, Room 121, Newark, NJ 07107.

Administrators have much broader responsibilities. They're not only professors or caregivers. They have a broader mission in shaping an institution. Women who assume administrative responsibilities achieve such positions after having distinguished themselves in one of the other areas.

As the numbers of women in medicine increase, more and more women will rise to positions of administrative responsibility within academic medical centers.

"[Senior administrators] at UMDNJ have been great supporters of women," says Gloria Bachmann,

GLORIA BACHMANN, MD



Figure 1. Gloria Bachmann, MD.

Choosing between pediatrics and obstetrics and gynecology was a difficult decision for **Gloria Bachmann, MD**. It wasn't until she assisted in the delivery of quadruplets that she was convinced obstetrics/gynecology was the specialty for her: "I was so overwhelmed during the birth of those four babies that I said, 'This is what I want to do.' It's such an exciting field."

Dr. Bachmann is associate professor in the Department of Obstetrics and Gynecology at UMDNJ-Robert Wood Johnson Medical School. She also is director of Middlesex Planned Parenthood, a clinical researcher, and a practicing physician.

A graduate of the University of Pennsylvania Medical School, Dr. Bachmann was the first woman to complete all four years of residency in obstetrics/gynecology at the Hospital of the University of Pennsylvania.

Much of her effort these days is spent on research. "I have a thirst for problem solving," Dr. Bachmann said. She currently is working on a two-part project, "Childhood and Adolescent Sexual Abuse and its Medical and Psychological Consequences in Adult Women." This includes a review of the world literature on sexual and physical abuse and a com-

MD, an associate professor in the Department of Obstetrics and Gynecology at UMDNJ-Robert Wood Johnson Medical School. "They have given women the opportunity to fulfill goals, and they have accepted women for their abilities and competence—not because they're male or female."

As the number of women entering medical school increases, the number of women faculty grow (Table). With this, the role of women in education will become more diversified. Interviews with five members of the faculty of UMDNJ show this diversity and the dedication of today's women physicians. ■

prehensive evaluation of over 600 women questioned on the subject.

Another area of continuing research interest for Dr. Bachmann is menopause, and the psychosocial health of women and their hormonal changes. These studies involve the emotional, sexual, and hormonal changes that occur at menopause, and are leading her to explore newer modalities of endocrine replacement therapy.

In addition to her research activities, Dr. Bachmann is chairman of the Women's Center Task Force, which is involved in updating, revising, and implementing new programs for women's health and, among other projects, is looking to establish a menopause clinic.

Dr. Bachmann finds academic medicine very challenging. "I can reach a lot more medical students this way and have an impact on the way they practice," she said. "One of my happiest moments at UMDNJ was when I received the Best Clinical Teacher award for 1986-1987 from the Family Practice residents. I felt so honored." Dr. Bachmann plans to continue teaching and instructing students in state-of-the-art health care for women. ■

NANCY GARY, MD

She has accomplished what some may think of as an eminent status, but to **Nancy Gary, MD**, there's still a lot more to come. Dr. Gary, a nephrologist, is professor of medicine and executive associate dean at UMDNJ-Robert Wood Johnson Medical School.

Currently on sabbatical, she is spending a year in Washington, D.C., as one of six Robert Wood Johnson health policy fellows in a program administered by the Institute of Medicine of the National Academy of Sciences, with assistance from the American Political Science Association. Designed for mid-career professionals, the purpose of the fellowship is to extend the public policy horizons of health professions schools, and improve the capabilities of their faculty members to study health policy and assume appropriate leadership roles in health activities at all levels. "It is an incredible opportunity.

It can't help but be an enormously enriching experience," said Dr. Gary.

Dr. Gary was both a clinical and research fellow at Georgetown University Hospital in the mid-1960s. "In 1965, nephrology was a new specialty. I was very interested in kidney dialysis." She continued, "There were only three fellowship programs in nephrology in the East. I applied and was accepted to all three. At Georgetown, I was the first and only woman in the program."

It was during that period that she considered a career in academic medicine. She loved to teach and take care of patients. "Academics was the right way to go," said Dr. Gary. "I could teach, do research, take care of patients, and work with people on the 'cutting edge' of science."

Dr. Gary joined the faculty of UMDNJ-Robert Wood Johnson Medical School in 1974 and assisted Dr. Robert P. Eisinger in establishing the Division of Nephrology. She was promoted to professor of medicine in 1981, and then was asked to become associate dean for academic affairs.

In her role as an administrator, Dr. Gary has been



Figure 2. Nancy Gary, MD.

instrumental in revising the undergraduate medical curriculum and has been responsible for strengthening relationships with affiliated hospitals and expanding clinical teaching sites. She also was involved in the development of programs to enhance recruitment of minority students, and spent the last year preparing information for the Liaison Commit-

tee on Medical Education for accreditation of UMDNJ-Robert Wood Johnson Medical School. ■

ELEANOR MASTERSON, DO



Figure 3. Eleanor Masterson, DO.

"If one student remembers something I taught him in order to save a life, my life as a teacher was well worth it," said **Eleanor Masterson, DO**, clinical associate professor of osteopathic sciences at UMDNJ-School of Osteopathic Medicine. A faculty member since 1979, Dr. Masterson received the 1986-1987 Excellence in Teaching award from the Foundation of UMDNJ.

When Dr. Masterson entered the Philadelphia College of Osteopathy in 1953, she was one of three women in a class of 105. "Some lecturers pretended not to see us until we proved ourselves. But I had a tremendous rapport with my classmates and I loved my teachers—especially those who expected the most," she said. Dr. Masterson fulfilled her own expectations of herself, graduating second in her class. "Today," she adds, "the barriers have disappeared and women are accepted for their abilities."

Dr. Masterson's entire career reflects her dedication to the teaching and practice of osteopathic medicine. She joined the faculty of her alma mater immediately after completing her internship, eventually holding associate professorships in three academic departments and serving as medical director of the clinics.

When the UMDNJ-School of Osteopathic Medicine was founded in Camden in 1978, she was invited to join the faculty and was named chief of the Osteopathic Science Department at Kennedy Memorial Hospitals-University Medical Center. Since then, she has remained active in undergraduate teaching and finds herself increasingly in demand as a spokesperson for her profession.

Eleanor Masterson always has been and always will be in academic medicine. "My aspirations haven't changed. I want to be the best teacher I can possibly be and pass on the best information." She continued, "I also want to be the best clinician I can be and provide the best care to my patients." ■

KAREN PUTTERMAN, MD



Figure 4. Karen Putterman, MD.

"Today, men and women are willing to admit that there can be more to the profession of medicine than taking care of patients, and it's all right to make use of your medical knowledge and training in other ways." **Karen Putterman, MD, MPH**, is acting vice-president for academic affairs at UMDNJ. Her career exemplifies the diversity of career opportunities available to her as a physician.

"I started out in pediatrics," said Dr. Putterman. "But, I had always been interested in public health because I could have a positive effect on a far greater number of people and even entire communities. I also found the epidemiologic and biostatistical aspects very stimulating intellectually."

JOYCE ROCKO, MD



Figure 5. Joyce Rocko, MD.

A novelty in 1972, **Joyce Rocko, MD**, was the only woman in the general surgery residency at Jersey City Medical Center. Dr. Rocko, a graduate of the University of Bologna, Italy, now is associate professor of general and vascular surgery at UMDNJ-New Jersey Medical School.

"I love surgery," said Dr. Rocko. "I went into trauma because I like the excitement. Trauma isn't 'cookbook'. You have to be your own genius."

Dr. Rocko finished her surgical training in 1976, having been chief resident in her final year. She remained on the staff of the Medical Center until 1981, when she was asked to become a full-time

In 1969, after completing an internship in pediatrics, Dr. Putterman entered a residency in public health and preventive medicine with the New York City Department of Health. In 1971, she was awarded a masters degree in public health from Columbia University.

In January 1987, Dr. Putterman left a career in the business world to enter the academic sphere at UMDNJ. As associate vice-president for academic affairs, she was responsible for education, research, and patient care issues at all six of the University's schools. Ten months later, when the senior vice-president accepted another position, Dr. Putterman was named acting vice-president. In this role, she participates in decisions about programs and policies that affect the University as a whole and works to coordinate academic activities among the schools. A new and exciting area for her involves enhancement of academic computing resources throughout the University.

Asked about her view of medicine as a career in the future, Dr. Putterman said: "I see a lot of opportunity for women and men in academic administration as well as the public health policy arena. These fields have become attractive for people with medical backgrounds who are attuned to what current society wants from the health professions." ■

faculty member at UMDNJ-New Jersey Medical School and director of Emergency/Trauma Services at University Hospital in Newark.

The switch to academic medicine was a rewarding one for Dr. Rocko. She has participated in a number of research studies on various aspects of trauma. She also has published and lectured on two topics of special interest to her: the management of portal hypertension and trauma in the pregnant patient.

Another reason she likes working in an academic setting is the opportunity to teach. "I love working with students and housestaff," Dr. Rocko said. "The residents are a challenge because they are always asking questions."

Dr. Rocko's interest in teaching extends well beyond UMDNJ. She has written several textbook chapters and she serves on the Continuing Education Committee of the American College of Surgeons (ACS). She is an author and editor of continuing education courses for trauma surgeons, and is the newly appointed medical coordinator of the Surgical Education and Self-Assessment Program of the ACS.

A valued member of many professional societies and University committees, Dr. Rocko plans to continue her career in academic medicine. "As long as there are trauma patients to care for, residents to teach, and the opportunity for research, I'll be happy," she said. ■

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[†]See Warnings and Precautions.

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CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, (3) patients with hypotension (less than 90 mm Hg systolic), and (4) patients who have demonstrated hypersensitivity to the drug.

WARNINGS

- Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
- Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
- Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
- Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, LDH, SGOT, SGPT, and other phenomena consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Dermatological events (See ADVERSE REACTIONS section) may be transient and may disappear despite continued use of CARDIZEM. However, skin eruptions progressing to erythema multiforme and/or exfoliative dermatitis have also been infrequently reported. Should a dermatologic reaction persist, the drug should be discontinued.

Drug Interaction. Due to the potential for additive effects, caution and careful titration are warranted in patients receiving CARDIZEM concomitantly with any agents known to affect cardiac contractility and/or conduction. (See WARNINGS.)

Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

As with all drugs, care should be exercised when treating patients with multiple medications. CARDIZEM undergoes bio-

transformation by cytochrome P-450 mixed function oxidase. Coadministration of CARDIZEM with other agents which follow the same route of biotransformation may result in the competitive inhibition of metabolism. Dosages of similarly metabolized drugs, particularly those of low therapeutic ratio or in patients with renal and/or hepatic impairment, may require adjustment when starting or stopping concomitantly administered CARDIZEM to maintain optimum therapeutic blood levels.

Beta-blockers: Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities.

Administration of CARDIZEM (diltiazem hydrochloride) concomitantly with propranolol in five normal volunteers resulted in increased propranolol levels in all subjects and bioavailability of propranolol was increased approximately 50%. If combination therapy is initiated or withdrawn in conjunction with propranolol, an adjustment in the propranolol dose may be warranted. (See WARNINGS.)

Cimetidine: A study in six healthy volunteers has shown a significant increase in peak diltiazem plasma levels (58%) and area-under-the-curve (53%) after a one-week course of cimetidine at 1,200 mg per day and diltiazem 60 mg per day. Ranitidine produced smaller, nonsignificant increases. The effect may be mediated by cimetidine's known inhibition of hepatic cytochrome P-450, the enzyme system probably responsible for the first-pass metabolism of diltiazem. Patients currently receiving diltiazem therapy should be carefully monitored for a change in pharmacological effect when initiating and discontinuing therapy with cimetidine. An adjustment in the diltiazem dose may be warranted. (See WARNINGS.)

Digitalis: Administration of CARDIZEM with digoxin in 24 healthy male subjects increased plasma digoxin concentrations approximately 20%. Another investigator found no increase in digoxin levels in 12 patients with coronary artery disease. Since there have been conflicting results regarding the effect of digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing CARDIZEM therapy to avoid possible over- or under-digitalization. (See WARNINGS.)

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in *in vitro* bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater

than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.3%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	Angina, arrhythmia, AV block (first degree), AV block (second or third degree—see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.
Nervous System:	Amnesia, depression, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.
Gastrointestinal:	Anorexia, constipation, diarrhea, dyspepsia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.
Dermatologic:	Petechiae, pruritus, photosensitivity, urticaria.
Other:	Amblyopia, CPK elevation, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarthral pain, polyuria, sexual difficulties.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

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See complete Professional Use Information before prescribing.

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Researching Women Physicians

BARBARA SMITH IRWIN, MLS



Very little has been written about the pioneering efforts, contributions, and careers of New Jersey women physicians. While three books have been published on New Jersey's medical history,¹⁻³ Rogers is the only one to include any reference to women physicians and an article by Cowen does not include women physicians.⁴

The purpose of this bibliographic essay is to provide an overview of the literature and to identify examples of library resources within the state for researching New Jersey women physicians as a stimulus to those who will write the history that has yet to be written.

LITERATURE OF WOMEN PHYSICIANS

The New Jersey Medical Women's Association (NJMWA), founded in 1924, is the first professional organization of the state's women physicians. In 1927, NJMWA joined the American Medical Women's Association (AMWA) and became known as "Branch Four." Current records are managed by the Academy of Medicine of New Jersey; some early reports and correspondence are on deposit at the Medical Archives of New York Hospital/Cornell Medical Center, New York City, among a collection of AMWA business records.

Other NJMWA activities can be traced in the *Journal of the American Medical Women's Association (JAMWA)* which began publishing in 1946 and was published briefly as *Woman Physician* from 1970 to 1971. The journal printed "History of Branch Four, New Jersey"⁵ and occasional biographies of outstanding members. NJMWA's history was updated in 1968, and published as a pamphlet.⁶ A newsletter was started in 1980 as *Physicienne* and continues on an irregular basis as *NJMWA News-*

letter. In 1986, NJMWA issued the first edition of a *Referral Directory* divided into two sections: membership roster and listing by specialty.⁷

"Women Physicians of New Jersey: The Early Era" appeared in 1984 in the *Journal of the Medical Society of New Jersey*.⁸ This article provides biographical sketches of 30 doctors from 1834 to the 1960s. This journal, now *NEW JERSEY MEDICINE*, is a key resource for articles about and by individual physicians; *Index Medicus* contains a cumulative index.

Essays on women physicians figure prominently in a forthcoming book. The Women's Project of New Jersey, Inc., a nonprofit organization, will publish *Past and Promise: The Heritage of New Jersey Women* in 1988.⁹ Editor-in-chief, Joan Burstyn, PhD, dean of the School of Education, Syracuse University and former chair of Rutgers University Women's Studies Department, states: "Three hundred women born as of 1923 have been selected for the book, including 26 New Jersey physicians and others who contributed to health sciences and nursing."

National reference sources providing biographical information for 19th century New Jersey women doctors include Lisabeth Holloway's *Medical Obituaries: American Physicians' Biographical Notices in Selected Journals Before 1907*,¹⁰ and *Notable American Women*.¹¹ Other useful sources include the American Medical Association (AMA) directories

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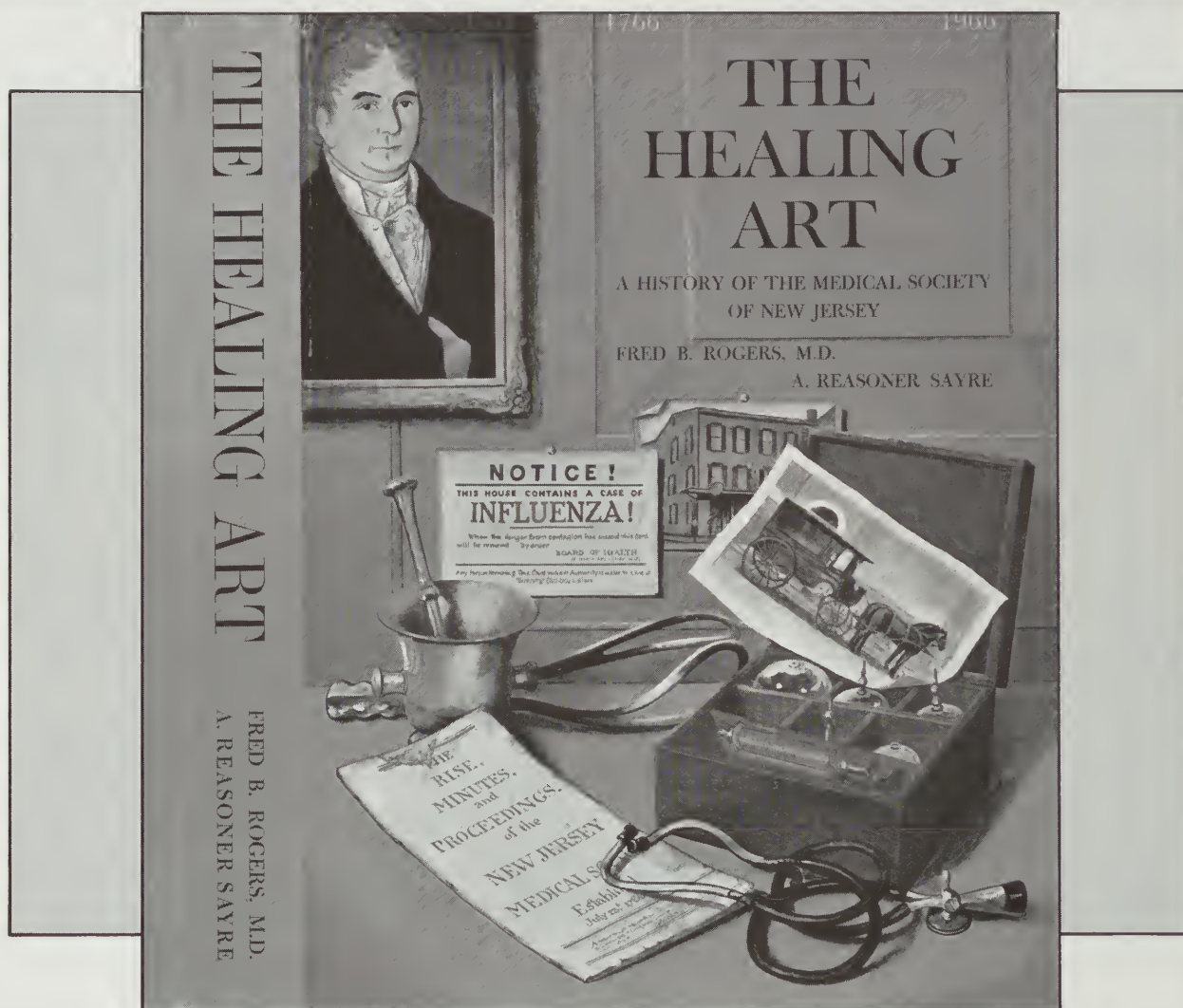


Figure 1. Cover of *The Healing Art* by Dr. Fred Rogers and A. Reasoner Sayre.

beginning in 1906 and continuing to the present. In 1979, AMA published the *Directory of Women Physicians in the U.S.*¹² Existing collections in nationwide repositories may be located in *Women's History Sources: A Guide to Archives and Manuscript Collections*.¹³ A monumental reference source of great value is *Women in Medicine: A Bibliography of the Literature on Women Physicians*; articles about and by women are identified in this work.¹⁴

Regional sources also are useful for identifying women doctors such as *Medical Register of New York, New Jersey, and Connecticut* (1862-1895). Studies of women's medical schools are valuable, as with *Send Us a Lady Physician*,¹⁵ because they may include students from New Jersey.

LIBRARY RESOURCES WITHIN NEW JERSEY

Six categories of libraries were selected for description: the state library, a medical school library,

an academic library, a private state historical library, a public library, and county/local historical institutions. While some collections in the first four categories are unique, the last two are representative of the types of materials which may exist in similar collections throughout the state.

New Jersey State Library (NJSL). The New Jersey Reference Division of NJSL contains a complete set of the *Board of Medical Examiners' Annual Reports* (1890 to 1954). Prior to the establishment of the State Board examinations, the only legal requirement to practice medicine in New Jersey was registration of a medical diploma with a county clerk. The Board reports list names of all physicians granted a license in the preceding year. Some reports also contain information on the physician's medical school, date of graduation, and residence. General information, such as the number of licenses granted to women, can be obtained through the reports; for example, in the period from October 1890 to Decem-

ber 1894, 19 women received licenses. During 1940, when the Board published its "Fiftieth Anniversary Report," 28 licenses were earned by women from a total of 240 tested: 16 for medicine and surgery, 6 for limited osteopathy, 4 for full osteopathy, and 2 for chiroprody.

The Jerseyana and Genealogy Collections of NJSL contain a wealth of resources for tracing individuals through their communities and families. One particularly useful source for locating birth, death, baptism, and marriage dates and places is *The Genealogical Magazine of New Jersey* with useful cumulative indexes prepared by

Kenn Stryker-Rodda. County and local histories also are available in the extensive Jerseyana collection.

The New Jersey State Library is located at 185 West State Street in Trenton.

University of Medicine and Dentistry of New Jersey—George F. Smith Library of the Health Sciences, Special Collections. The State's only New Jersey Medical History Collection is being developed at the Smith Library as a part of History of Medicine resources.

The University's History of Medicine Collection originated as the library of the Academy of Medicine of New Jersey which the Academy donated to the Smith Library. The gift included New Jersey historical materials, such as *New Jersey Medical Reporter* (1847-1858) and *Transactions of the Medical Society of New Jersey* (1766-1903). Also at the Smith Library are complete runs of the *Journal of the Medical Society of New Jersey* (1904 to present) and the *Membership Directory of the Medical Society of New Jersey* (1953 to present). In addition, there are newsletters, bulletins, and journals from many county medical societies where information on local activities of women physicians may be found.

Since designating the New Jersey Medical History Collection a priority area to be developed, the Smith Library actively has collected materials on women physicians. NJMWA and AMWA publications are available. There are biographical files for women physicians, both historical and contemporary. Other examples of resources include a videotape interview with Dr. Eva Brodtkin, first woman dermatologist in



Figure 2. The George F. Smith Library of the Health Sciences.

the state,¹⁶ and an oral history interview with Dr. Lena Edwards (1900-1986), a black physician who was nationally recognized for her dedication to improving medical care for the elderly and poor.¹⁷ There also is a scrapbook kept by Frances B. Tyson, MD (1874-1971), founder of the Leonia Youth Museum; her photograph portrait and other biographical materials are on file.

HISTLINE, the National Library of Medicine's online bibliographic database for the history of medicine, is one of the databases available at the Smith Library. The main collections contain *Index Medicus* and *Index Catalogue of the Library of the Surgeon General's Office* for searching articles by specific women physicians.

The UMDNJ-Smith Library is on the Newark Campus at 30 Twelfth Avenue.

Rutgers University Libraries-Alexander Library, Special Collections. An outstanding collection of New Jerseyana is contained in the Sinclair Collection, including extensive biographical directories. These directories are useful for locating information on prominent physicians in a specific community or county. One such example is a biographical sketch of Anna E. Griffith, MD, found in a southern New Jersey directory.¹⁸ The Rutgers' collection owes much to the efforts of Donald A. Sinclair, former curator, who acquired most of the directories during his tenure. Although retired from Rutgers, Sinclair has compiled a "New Jersey Biographical Index" as a companion volume to a bibliography of collective biographical sources. The latter still is in process, but Sinclair expects the index to

be published in the near future. Its significance as a reference tool for locating information on all physicians in New Jersey is apparent immediately; among sources indexed by Sinclair are biographical materials in the *Journal of the Medical Society of New Jersey* from the mid-1850s up to 1971, *Transactions of MSNJ*, 11 volumes of *Medical and Surgical Reporter*, and county medical society publications.

The Alexander Library is located on College Avenue in New Brunswick.

New Jersey Historical Society (NJHS). The Manuscript Collections of NJHS contain papers of Dr. Marietta H.C. Woodruff who graduated from New York Medical College for Women in 1874, including her case study of epilepsy conducted in 1908. Another Woodruff manuscript in the Society is a book of births, family information, and medical facts about the deliveries recorded by Dr. Woodruff from 1873 to 1900 in Boonton.

NJHS Manuscripts contain the archives of the Academy of Medicine of New Jersey (1775-1968). Among the papers in this group are records of other state and local medical organizations, such as the Physicians Club of Newark (1917-1924) and the Essex County Pathological and Anatomical Society (1962-1968).

NJHS has been designated the repository for the Women's Project of New Jersey archives when the book, *Past and Promise: The Heritage of New Jersey Women*, and a travelling exhibit have been completed; the records will consist of comprehensive files for all the women in the book and a card index of approximately 1,200 others considered for the project including physicians.

The NJHS Library contains a copy of *Report of the Association for the Advancement of the Medical Education of Women . . . 1878*.¹⁹ In addition, there are published histories of various county medical societies and family histories.

The New Jersey Historical Society Library is located at 230 Broadway in Newark.



Figure 3. Historical Society of Princeton.

The Joint Free Public Library of Morristown and Morris Township. Morris County is the focus of the Library's excellent local history and genealogy collection. Although the resources are unique for Morris County, they are representative of the types of materials which may be found in similar collections in other public libraries.

"The Curtiss Collection is one of our most precious resources," according to Lois Densky, archivist. "It consists of approximately 6,000 glass plate negatives and corresponding positive prints taken by a local commercial photographer from 1903 through 1938. There is an online computerized index for subject access." The collection includes many photographs of hospitals, hospital staffs, and health care.

Another example of a resource that local public libraries may have is a photographic album, such as one of Greystone Park in Morris Plains. Forty-six black-and-white photographs show the professional staff, administration, interiors, and exteriors of Greystone Park, a New Jersey psychiatric hospital.

Local history archives include a collection from the Morristown Memorial Hospital (ca. 1892-1981) with annual reports, Diamond Jubilee celebration material, and staff directories. A collection such as this provides documentation for women physicians affiliated with the hospital.

Gloucester County Historical Society (GCHS) and the Historical Society of Princeton (HSP). Libraries in county and local historical organizations are good resources. A researcher would more likely find a complete set of city directories in local repositories, such as GCHS. City directories, the predecessor of telephone books, are valuable sources through which physicians' offices and residences can be identified; the addresses are the keys to census records where there is still more data. State and U.S. census records on microfilm sometimes may be available in local repositories, but more often are found in the NJSL and larger institutions.

In addition to library and museum collections, historical societies often uncover unique materials while mounting exhibitions. Such was the case at the Historical Society of Princeton several years ago when an exhibit was being prepared on the community's medical history. An unpublished autobiography by Princeton's first pediatrician, Dr. Jeanette Munro, was located for the exhibit.²¹

Names and addresses of other historical societies may be located in *Historical Organizations in New Jersey: A Directory*.²² Listings identify library collections but do not provide information on types of materials. For information on manuscript collections, see *Historical Manuscripts: A Guide to Collections in the State*.²³

AN OUTSTANDING COLLECTION

Despite a wealth of documentation within New Jersey, recognition must also be given to a special library collection with resources that include New Jersey women doctors: The Medical College of Pennsylvania (MCP), Archives and Special Collections on Women in Medicine, 3000 Henry Avenue, Philadelphia, Pennsylvania. One of the most comprehensive collections in the United States on women physicians, the archives contain records of the school's predecessors, Female Medical College of Pennsylvania

and Women's Medical College of Pennsylvania.

Two types of materials are available in the collections: published articles and personal papers. The articles can be accessed through the bibliography *Women in Medicine*.¹⁴ Among New Jersey women whose personal papers are on deposit are Dr. Ellen C. Potter (1871-1958), the first woman to hold a position of cabinet officer in any state cabinet in the United States; and Dr. Mathilda Vaschak, who served as president of the New Jersey Industrial Medicine Association (1963-1964).

CONCLUSION

While little has been written about New Jersey women physicians, there are untapped resources awaiting researchers in a variety of libraries throughout the state. Selected holdings were described for statewide collections at the New Jersey State Library, UMDNJ-Smith Library, Rutgers-Alexander Library, and the New Jersey Historical Society. Representative holdings for public and county/local historical libraries were cited. One out-of-state collection at the Medical College of Pennsylvania in Philadelphia also was described. The history of women physicians in New Jersey deserves recognition. ■

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Our First Woman Dermatologist

MORRIS H. SAFFRON, MD



Figure 1. Eva T. Brodtkin, MD.

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fears. Eva entered Cornell University (her mother's choice) in 1916. Although enrolled as a premedical student, Eva managed to take many elective nonmedical, cultural courses as well as the prescribed scientific ones, and the pleasure in these lasted all her life. After graduation from Cornell in 1920, Eva began her professional studies at the Women's Medical College of Pennsylvania in Philadelphia. During her third year, she met her future husband, Harry Brodtkin of Newark, who was studying at the Jefferson Medical College. Their marriage lasted 60 years and was filled with mutual admiration and love for all the years spent together.

After graduation from medical school in 1924, Eva Brodtkin searched for a one-year rotating internship, required of all physicians before receiving a license to practice. Many hospitals still refused to accept women as interns, citing the difficulty of providing proper quarters. In spite of this, Dr. Brodtkin applied for and was accepted—as an “experiment”—at Muhlenberg Hospital in Plainfield. Wisely, she immediately decided not to rely on her femininity to avoid difficult tasks; instead she insisted on participating equally with the four male interns in riding

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On March 7, 1899, Eva T. Brodtkin was born in Brooklyn, New York, the daughter of Isidor and Theresa Tompkin. Isidor, just completing his medical studies at Long Island Medical College, set a pattern for the whole family, for two brothers also became physicians and a sister is said to have been the first woman graduate of the Brooklyn College of Pharmacy.

When Eva was only seven months old, her enterprising young father moved his small family to the village of Califon in Hunterdon County, where he was to carry on a country practice for 35 years. His daughter vividly recalls life in this rural setting, especially how the family would gather for breakfast at 5:30 A.M. to see father off on his long rounds in a horse and buggy.

It was at this early period of her life, also, that the young Eva became imbued with an *idée fixe* that she never lost; namely, that she would study medicine and assist her father, whom she adored. But educational facilities in rural areas then were primitive: eight elementary classes were taught in two modest rooms. Later, when she was sent to High Ridge High School (six miles away), transportation was so inadequate that she seldom returned home before 6 P.M.

MEDICAL EDUCATION

When the time arrived for deciding on a career, Eva found her parents very concerned about the problems confronting women in medicine, but her drive was so great she succeeded in calming their

ambulance and carrying patients on stretchers. By the time she finished her internship, Eva Brodtkin had received such high praise from staff and administrators of the hospital she felt she had broken down forever any resistance against female interns at Muhlenberg Hospital—and that was reward enough.

After her internship, Dr. Brodtkin entered general practice in Irvington, but soon moved to Newark where she shared office space with her husband. In Newark, her practice primarily was devoted to obstetrics; as a woman physician, she encountered the usual resistance from male and female patients.

After several years of general practice, interrupted only temporarily by the birth of two children, Eva and her husband decided a more specialized type of practice—one that would permit her to stay close to the office—would be more advantageous to the young mother. Eva chose dermatology—almost haphazardly—partially because it was one which did not require a residency.

DERMATOLOGY TRAINING

Eva then approached Dr. Henry J. Wallhauser, the veritable Nestor of New Jersey dermatology, for advice. Dr. Wallhauser was well-known for the famous Newark City Skin Clinic, which he supervised for 50 years; he also was consultant to 12 local hospitals, as well as being a prominent figure on the national scene. Dr. Wallhauser was a kindly man, and he became interested in the young lady who wished to enter his specialty. He tried to calm her fears about the prospects of a career in dermatology by telling her he too had similar fears in the 1880s when he consulted George Henry Fox, then the dean of New York dermatology.

Dr. Wallhauser invited Eva to attend skin clinics at the City and Beth Israel Hospitals. Through him she met Dr. Francis J. McCauley, Dr. Wallhauser's office associate, head of the skin clinic at Saint Barnabas Hospital. This was the beginning of a lengthy affiliation with that institution; eventually Eva succeeded Dr. McCauley on his retirement, remaining as attending dermatologist until her own retirement in 1964.

STUDY IN NEW YORK

In 1929, Dr. Brodtkin began ten years of study at the outstanding Skin and Cancer Hospital in New York, which was affiliated with the Postgraduate Medical School of Columbia University. For three years, Eva Brodtkin travelled to New York five days a week; it was only after she had received an appointment as Clinical Assistant at Postgraduate that she cut her attendance to three days a week—and this continued for the following seven years. During this period, she worked with Drs. Isador

Rosen, Max Scheer, Joseph J. Eler, and George Miller McKee.

At the end of this ten-year stint, Dr. Brodtkin felt sufficiently prepared to take the formidable examination of the American Board of Dermatology and Syphilology. Although she had been exempted from taking the written examination, she was subjected to a rigorous oral questioning by Dr. C. Guy Lane of Chicago, who then was Secretary of the Board. Only 50 percent of the applicants passed the examination; Dr. Brodtkin was successful and returned to New Jersey in triumph as the first qualified Board-certified dermatologist in the entire state.

DERMATOLOGIST

In 1939, Dr. Brodtkin was invited to join the Northern New Jersey Dermatological Society (later the New Jersey Dermatological Society), which had been founded in 1934 with Dr. Wallhauser as its first president; members included Dr. Bart James, and Dr. Francis McCauley, Dr. Eugene Miller, and Dr. Frederick Licks. During the ensuing decade, Eva Brodtkin played an increasingly important role in the activities of the Society, becoming its president in 1952 to 1953. A few years later, when the Medical Society of New Jersey formed a Section on Dermatology under the aegis of Dr. Emanuel M. Satulsky of Elizabeth, Eva Brodtkin again played an active part in it, planning the annual meetings in Atlantic City, and serving as secretary in 1959 and president in 1960.

OTHER INTERESTS

There still was another organization which played an important part in Dr. Brodtkin's way of life. During her internship she had met a kindred spirit, Dr. Clara DeHart Kraus, a Plainfield physician who had conceived the idea of forming a society of women practitioners of medicine in New Jersey. Dr. Kraus insisted on enrolling Eva as a member of the newly formed New Jersey Medical Women's Association (later affiliated with the National Medical Women's Association as Branch Four) by paying Eva's initial dues of \$2. Through the efforts of the Society's activists, more and more hospitals were encouraged to accept women as interns. In an article written by Drs. Brodtkin and Lydia B. Hauck, a psychologist, we learn how New Jersey women doctors cooperated with their colleagues in the New York Chapter in pressing for the passage of a bill to commission women physicians in the armed forces. (Others working on these problems who became friends of Dr. Brodtkin included Dr. Rita Finkler, the well-known endocrinologist, and Dr. Carye-Belle Henle, the first board-certified female radiologist in New Jersey.) During the war years, 1941 to 1943, Eva



Figure 2. Dr. Brodtkin was affiliated with Saint Barnabas Medical Center as an attending dermatologist until 1964.

Brodtkin served two consecutive terms as President of Branch Four, and was named Woman of the Year by the Association in 1964. She also was active in other nonmedical groups, including the League of Women Voters.

World War II brought changes into Eva Brodtkin's life. Her husband Harry, head of thoracic surgery at Beth Israel Hospital, was away on active duty for over five years, and the responsibility of raising their three children fell completely on Eva's shoulders. It was only on her husband's return, that they were able to resume their former extensive series of travels, which had taken them on safaris to Africa, Australia, Asia, and other remote areas.

RETIREMENT

In 1966, Eva Brodtkin decided to leave the office on Osborne Terrace in Newark which she had occupied for 40 years and move to Irvington. She shared office space with Dr. Jacob Bleiberg, with whom her son Roger then was associated.* By 1977, Eva's eyesight was beginning to fail and she closed her practice; also, her husband Harry's health was poor and he required his wife's constant care and devotion.

At 88 years of age, Eva Brodtkin resides in East Orange where she is very much the *grande dame* and the center of attraction for her three children, their

mates, and her seven grandchildren. Always an outspoken person with liberal ideas, she takes a stern view of the many changes in the practice of medicine that have taken place since her early days. Eva feels that the physician of today has lost the empathy with patients that dominated her own attitude. She is concerned with the problem of excessive charges for medical care, the burdens of malpractice insurance, and the needs of the impoverished who are not covered by medical insurance of any kind; and she feels that some form of governmental underwriting and control of universal medical care is inevitable—and, indeed, desirable.

Happily, Eva Brodtkin still retains all her faculties, including a voice which to this writer's knowledge has not changed its timbre in the past 50 years. For the future, consequently, all we can wish for this remarkable woman who had done so much for humanity, is good health *ad multos annos*. ■

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*Roger Brodtkin, a dermatologist, now is Clinical Professor of Dermatology at UMDNJ-New Jersey Medical School.

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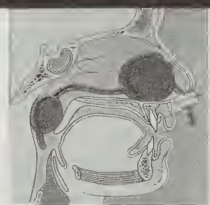
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CUMULATIVE INDEX

Princeton's First Pediatrician

JEANNETTE MUNRO, MD



Jeannette Munro was born in Philadelphia in 1894, but grew up in Madison, Wisconsin, where her father was Chairman of the University of Wisconsin History Department. She received her undergraduate degree from that institution in 1915; then after almost eight years as a social worker in New York City, she entered the Medical School of the University of Wisconsin, from which she received her medical degree in 1927. Because the school did not then have a hospital for training in clinical medicine, students went to Wisconsin and Chicago hospitals for periods of study and to La Crosse, Wisconsin, for preceptorships which would give them practical training and experience. After graduation, Dr. Munro spent a year in general internship at the Worcester Memorial Hospital in Worcester, Massachusetts, and two years as a pediatric intern at the Massachusetts General Hospital in Boston; she then set up practice in New York City. This was only marginally successful economically, so in 1933 Dr. Munro decided to move to Princeton, where her mother lived, and practice pediatrics in that city. She helped to found a Well-Baby Clinic and took part in other civic endeavors in Princeton and later in Hightstown, when she retired there. She remained active until her retirement at age 70. She died in 1986. The following excerpts are from Dr. Munro's unpublished autobiography.

People used to ask me, "Did you have a hard time getting into medical school?" No, I didn't because I set my sights reasonably and modestly. A friend of my mother's, Dorothy Reed Mendenhall, herself a graduate of Johns Hopkins Medical School, and one of the best known women doctors in the country, wanted me to challenge Harvard, then and for many years to come a completely male bastion, and already known as the finest medical school in the country. I was content to leave this effort to some brilliant woman aspirant of the future who might be counted on to outdistance all male competitors. I recognized at that time that I was not of that caliber. I felt that I would be welcomed at Madison and I was right. They took me entirely on my former record and I found myself enrolled without fanfare in the first four-year class of the University of Wisconsin Medical School. We were a small, but I think carefully chosen, class of six women and 19 men.

Medical school was from the first day a grueling experience, as it is now. Our course was divided into two years of pre-clinical work and two clinical years. Our pre-clinical courses had been given at Madison for some years but the clinical years had to wait for the establishment of a large general hospital which could eventually be expected to produce a rich supply of clinical material for practice and demonstration.

We were taught that a doctor was expected to work long hours, master tremendous amounts of material from new and unfamiliar fields, and always bob up cheerfully for more. In the first year we were plunged into the most fabulous task that anyone could imagine: we had to learn the name of every bone, joint, nerve, blood vessel, organ, and tissue in the human body. We dissected bodies in a cloud of formaldehyde and other unpleasant odors. I had the cadaver of a man who had died of peritonitis and I was resentful of the fact that dissection of the normal contents of the abdominal cavity was completely impossible.

Later on people would ask me, "Didn't you have an awful time getting established as a woman doctor, let alone a specialist?" I want to testify here that I expected to meet and did meet a certain amount of male chauvinism. However, taking it all-in-all, at Wisconsin and later in Princeton, I really got a fair deal from my male colleagues. I attribute this mainly to the essential good manners and kindness of the medical fraternity in both places.

This article contains excerpts from Dr. Munro's unpublished autobiography. Other sections have appeared in Princeton History 5:27-37, 1986. Requests for reprints can be addressed to Estelle Brodman, PhD, 19-09 Meadow Lakes, Hightstown, NJ 08520.

One thing we "hen medics" always had to face up to was the dirty story, the indescribably funny pornographic anecdote told in a group of men with the express aim of bringing a blush to the cheek of the one woman present. I always tried not to blush but not to laugh uproariously either.

CLINICAL YEARS

In medical school as we started on the real core of our medical course, the clinical years, we were introduced immediately to a universal reference book, a veritable bible for the medical students and the doctor in practice, known to us as "Osler." When you wanted to know any fact about any malady known to the human race, you just opened your Osler and there it was. The old master had been there before you, and he passed on to you in clear simple English, the history and characteristics of the disease, its pathology, the cause when known, the possible and probable complications, the prognosis, and what kind of treatment might help the patient. Treatment was the least satisfactory thing of these descriptions. There was a scant handful of maladies at that time for which there was any specific treatment available. We had salversan for syphilis and quinine from the "fever bark tree" for malaria. There were the recently developed antisera to fight diphtheria, meningococcus meningitis, and tetanus; cod liver oil to prevent and treat rickets; and finally insulin, the new specific which gave such wonderful promise for controlling diabetes. Controlling diabetes was just coming into its own; insulin had been isolated and we were learning how to use it.

To me, of course, the most important part of the clinical years was the pediatric course. Our textbook was the 1925 edition of Julius Hess's authoritative work, "The Care and Feeding of Infants." Hess was a splendid clinician and a revered teacher. In going through the book now I find many interesting features. There is a whole chapter on the wet nurse, and I can remember from my course lectures on the subject which stressed such factors as the position of the wet nurse in a home, how to keep her happy and therefore productive, and how to treat the child of the wet nurse. I never met up with a wet nurse in a home during my years of practice, but we could have used one at times.

In outlining the care of the premature infant, Hess described the use of a nasal spoon, which I never understood and actually never saw in practice. He also advocated the Breck feeder which I tried and found unsatisfactory. The simple medicine dropper usually worked better. Jackets for premature infants were made by nurses in those days. Layers of gauze were quilted over cotton batting to make a garment which covered every inch of the well-oiled infant



Figure 2. Dr. Jeanette Munro examining a patient in 1949.

except for a little circle for eyes, nose, and mouth. Hot water bottles were strategically placed. We certainly learned a whole new aspect of the premature infant, color, respirations, activity, when we first placed him naked in the isolette. Before the incubator was in use, when oxygen was needed, it was supplied through a face mask. We all know the tragic consequences that followed the first enthusiasm for free flowing oxygen in the early incubators: many infants whose lives were saved in the first incubators were later found to be blind because of the inhalation of too much oxygen.

Because the Madison hospital was very new and small it was necessary for us to go elsewhere for actual clinical training. Obstetrics and dermatology were handled in Chicago during our third year of medical school, and there was a preceptorship at La Crosse, Wisconsin, in the fourth year. In both instances my classmates and I were the first of our sex to take part in the program. In Chicago we all attended a lively prenatal clinic run by the hospital in a building near the settlement in which we lived. All first deliveries were done at the Chicago Lying-In Hospital but subsequent deliveries which promised to be normal were performed in the homes by teams of two students, supervised by a resident from the hospital.

On our team there always was a more experienced student and a novice, besides the very superior resident from the Lying-In Hospital. The less-experienced student carried to the home a large bag containing sterile sheets and instruments. We were never allowed to put this down in any street car or on any other surface except that, if we had a seat, we could hold it on a supposedly relatively clean lap. Otherwise the lowly assistant stood holding a swaying ring above her head with one hand and the bag just above the floor in the other. If the delivery did not appear imminent when we arrived we were left

by the resident-in-charge with provision for telephoning him in good time. Before we left the house we were supposed to fill out the birth certificate complete with the name of the newborn.

As part of our fourth year curriculum another woman classmate and I found ourselves joining the staff at a small hospital at La Crosse, Wisconsin. It was a first preceptorship—a first for the hospital and a first for us. We were there to get practical training and experience under skilled practitioners, and did we get it! We had not received our medical degrees, but were addressed as doctor and treated as such, in itself an exhilarating and sobering experience. We were interns in everything but name.

The clientele of the hospital was about 95 percent composed to old Norwegian farmers and their wives with their American children and grandchildren. When we followed Dr. Adolf Gundersen on his morning rounds we sometimes found that the whole procedure was conducted in Norwegian. The hospital had two large wards, for males and females respectively, and many double and several deluxe single rooms. These had private baths and were situated at corners assuring cross ventilation in the hot Wisconsin summers. These single rooms were expensive—\$5 a day. Relatives who wanted were allowed to stay with the patients in the single or double rooms.

We were the only interns at the hospital at the time, but there had been others, as witness the evidence of our quarters: we two women had a long narrow room off the medical staff sitting room. We ate with the resident staff—nurses, technicians, and office workers. The food was nondescript American boardinghouse food; later, when we took turns dining with the doctors on Sundays in their homes, we discovered the real Norwegian delicacies.

After dinner the first night we were plunged immediately into our new role. The youngest Dr. Gundersen introduced us to three patients who were to have gallbladder x-rays the next day. Each was to have an injection the night before and the young doctor demonstrated the technique on the first victim. Then, under his direction, we each in turn plunged a large syringe full of contrast medium into the elusive vein. Next evening there were four "gallbladders" waiting for us and we were alone. No one fainted, no one fell over dead. Already we began to get a certain confidence, even a feeling of developing skill. This was a good sample of the methods by which we were taught at La Crosse. We had no didactic lectures but lots of things to observe and procedures to follow. For the first time the responsibility of life and death was in our hands. The gist of the first lesson that first night was that you had to be tough and resolute if you wanted to become

a doctor. One lesson learned in those first days, and emphasized over and over in experiences in the wards, was that a doctor was willy nilly in a position of authority. The average patient looked up to us and expected us to assume responsibility.

INTERNSHIPS

After graduation there came for most of us a general internship of one year, and mine was spent at the Worcester Memorial Hospital in Worcester, Massachusetts. Women interns never were welcomed in most of the prestigious hospitals in those days, but this was a hospital that took only women. We came from all over the United States and one of us was from a Canadian medical school. We thus represented a wide variety of basic training; for example, giving ether had not been part of our course in Madison and I had to bone up on the subject with a great deal of help from my fellow interns.

In Worcester we had good solid fundamental training in medicine and surgery, and in obstetrics and gynecology, which to many of us was what medicine was all about; and we had excellent experience. Pediatrics was just a fringe affair which every general practitioner (GP) had to know something about, but we had no real pediatrician on our staff. We had children on the medical and surgical services and infants in obstetrics, of course, but no real pediatric service.

One facet of the life of the intern I resented at Worcester, and also later in Boston. We were housed and fed, but not particularly comfortably or well. We received not a cent of money, but were expected to work long hours, meet horrifying emergencies, and appear briskly and efficiently the next morning no matter how disturbed the night might have been. We had no regular time off, but made arrangements with our fellow residents to do double duty at times. We who came through were tough and resistant.

I realized in Worcester that to get any real pediatric training I would somehow have to get into a large teaching hospital. By pure luck I got my chance. Dr. Higgins from Cincinnati, I think, had been brought in to head pediatrics at the Massachusetts General Hospital (MGH) and he brought with him a woman assistant formerly at Wisconsin. She persuaded him to give me a chance. Even then I was not exactly of the same status as the male interns. The first year I had to live outside the hospital and the second year I was isolated in a nursing residence where I could not possibly get in on the evening discussions or informal sharing of the days' lessons.

I had to be at MGH by 9 A.M. and then the chief pediatric resident gave me an assignment for the day. I was in the clinic three mornings a week. On the other days I took histories of patients in the mornings, worked up their cases, and presented

them at pediatric grand rounds in the late mornings. In addition, we were supposed to supervise the care and feeding of the children in the surgical wards of MGH and also those in the ear, nose, and throat and ophthalmic wards.

I spent two years on the pediatric wards of MGH. There we saw many seriously ill infants and children. We had a small epidemic of meningococcus meningitis one year and my friend, the only other woman on the house staff at the hospital, died of it. We treated the disease by repeated lumbar punctures, sometimes as often as every eight hours, and the introduction of meningococcus antiserum into the spinal canal. The rule was to give 5 ml less than the amount of spinal fluid that had been withdrawn. There was a pitifully small number of cases that survived and most of them had residual neurologic defect. Subacute bacterial endocarditis was seen frequently; this of course was a uniformly fatal infection at that time, as were influenzal bacillary meningitis and tuberculosis meningitis.

During my time at MGH, Minot's discovery of the value of liver in pernicious anemia was just being publicized and of course we tried the liver treatment for all the severe anemias of childhood. All sorts of dainty liver dishes were concocted using cooked liver, and one inspired dietician even evolved liver ice cream.

We saw many children with pyuria. The treatment started with an attempt to wash out the kidney using mildly alkaline fluids in large amounts by mouth, the theory being that many bacteria did not thrive in an alkaline medium. If this did not work after about two weeks; there was then a switch to acid treatment. We used ammonium mandelate by mouth; fluids were restricted markedly. Any bacteria that could stand alkali were supposed to be completely routed by the acid treatment. And, strange to say, the method often worked and seemed to pay off.

Otitis media was a condition we were always meeting, and as pediatric interns, we were responsible for the general care and feeding of the children treated. The old time routine involved opening the ear drum widely at the first suggestion of bulging, and reopening it for better drainage, often repeatedly, if the temperature continued to be elevated. The ear canal was irrigated several times a day. In spite of this heroic treatment, we performed numerous mastoid operations and always had children with sinus thrombosis and brain abscess in the house for treatment and care.

We supervised feeding in a ward for children with gonorrheal conjunctivitis, with a population of approximately 20 newborn infants. Silver nitrate was used in the newborn's eyes in the hospital deliveries



Figure 3. The Princeton Hospital in 1938 where Dr. Munro practiced. (©The Medical Center at Princeton)

I wanted at least to keep in my field of choice, pediatrics. But there were no certified specialists in any brand of medicine then. Except in a few large medical centers, there were no doctors recognized as pediatricians. We were all GPs together, theoretically able to handle all medical problems as we met them. I had to take on anything in the medical field that I could get. All my volunteer work was in the clinic of the Babies Hospital, but the paid work I found available was a hodgepodge of

at that time, but evidently it was not a recognized legal must in the many home deliveries.

During my second year at the MGH I had a wonderful windfall. I was appointed to work one afternoon a week at a well-baby clinic in the neighborhood and was paid \$5 a session. I should really have paid for the privilege. It was my introduction to something very like private office practice and I learned a lot from the experience. I might note that the \$5 payment was a godsend. It was the only money I received for services in three years of postgraduate training, and \$5 was \$5 in those days. In later years I established a clinic in Princeton, based on that in which I had worked in East Boston, and later I started one in Hightstown when I retired there.

NEW YORK AND THE DEPRESSION

In the summer of 1930 I decided to launch my own practice in a city I knew and loved—New York. I had no career direction during my medical course and none during my postgraduate training. Certainly I knew nothing about the handling of medical practice as a business; I had always worked for a well-established institution and been paid a salary. My vague intention was to combine my two disciplines, social work and medicine, working for some such organization as the Children's Bureau or the New York City Health Department. I did not want to make money. I just wanted enough to live on comfortably while I engaged in very interesting work, but the literal down-to-earth position in 1930 was that the bottom was very shaky under the business of private medical practice. PhDs were selling apples on the street corners—why not MDs?

GP services. I examined girls and women who had signed up to use the YWCA pool, also others who wanted to work as waitresses at Schrafft's. I went over children bound for various "Fresh Air" camps. I was a paid worker in an evening clinic for working girls. But the sources of the largest dollops of cash was the work I did as stand-in for busier doctors. I made house calls all up and down Manhattan, day and night. Sometimes I was on call for five or six doctors, some of whom I did not even know. Some doctors filled me in on the history and paid in cash, but most just gave me a name and an address.

FINALLY: PEDIATRICIAN IN PRINCETON

In New York I was in the anomalous position of working as a GP while I wanted more and more to be a pediatrician, for which I had real specialty training. Then my father died suddenly, leaving my mother alone in Princeton. There was I, the unmarried daughter, who in the Victorian age would have been expected to give up everything to care for and cherish an ailing parent. I wasn't ready to give up my profession; but one of my successful and well-heeled women colleagues gave me a very knowing bit of advice. She told me I would never be recognized as a pediatrician unless I limited my practice to pediatrics, and I could not do that and survive in New York. She advised me to find a smaller place where a pediatrician was needed. There was the answer to the dilemma with my mother. I decided I would move to the highly literate small community of Princeton with its ambitious new hospital.

I must admit that no one in Princeton greeted my arrival as the answer to prayer. Our family doctor told me Princeton did not need, and would not sup-

port, a pediatrician—after all, there was a pediatrician in Trenton. Another Princeton doctor did not advise me not to come, but did suggest that I should not represent myself as a specialist and should never charge more than \$2 for an office visit or \$3 for a house call.

My office arrangements were quite elastic. I transferred my modest professional equipment to my mother's home, set up a makeshift office there, kept on my paid jobs and my Babies Hospital Clinic appointment, and commuted to New York while I tried out things in Princeton. Looking over 45 years, I know that sheer luck played a major part in the success I had in establishing myself as a pediatrician in Princeton. In the first place, it was luck that I was ready to tackle Princeton at the moment when the community was ripe for a pediatrician and when there was no charming and well-trained young man to challenge me in the pediatrics field. The second and prime piece of luck was that I fell heir to the position of doctor for the Princeton Nursery School—the equivalent of a first-class postgraduate course in private practice, which I needed desperately.

My previous training had all been in a hospital setting with its severe, life-threatening diseases, but with none of the common garden variety of sore throats, earaches, digestive troubles, or the common contagious diseases of children. Moreover, I had no experience in handling the behavior problems of normal healthy children, that take up about half of the pediatrician's time. I watched the nursery school workers with awe and admiration.

With my slowly growing practice I began to know and try to develop good relations with the medical group already active in Princeton. They were wary of me as the first woman doctor among them and also as a representative of that strange and threatening new breed, the medical specialist.

I worked in the Princeton Hospital; this had been started as a result of the flu epidemic of 1918 and originally could accommodate 22 patients under the care of the five GPs already active in the community. The building was inadequate in size, poorly planned and managed, crowded, a firetrap, and poorly ventilated. A new building was opened in 1928 and for many years I was the only pediatrician and the only woman on its staff. The hospital of that day had 56 beds and 12 bassinets, an operating room separate from the delivery room, and a 5-bed children's ward. There were only eight doctors on the staff, one nurse anesthetist, and one laboratory technician.

As the head of the tiny pediatrics department I was able to supervise conditions in our little ward, but only to a limited extent. But one thing about which I had some say in the Princeton community

was the routine immunization schedule as recommended for the well child: three double shots of pertussis vaccine somewhere between 6 and 8 months, three shots of diphtheria toxoid at 9, 10, and 11 months, smallpox vaccination at one year, and two shots of tetanus toxoid 3 months apart after the smallpox vaccination. No wonder they dreaded the doctor's office! During my early years of pediatric practice I had several patients die of pneumonia every winter, but not without a terrific struggle. Meticulous nursing care was all-important for survival in that era and I feel that the quality of the bedside nursing, in the day of 12-hour shifts for \$8 a shift, was extraordinarily high.

Many children's diseases which were rampant in the 1930s are seldom seen and not at all threatening today: diphtheria, scarlet fever, whooping cough, and measles, which came in waves every two to four years. Polio, the most dreaded of all, was a recurring nightmare. Mastoid operations were commonplace. Rheumatic fever was a long drawn-out recurring disease. Newborn babies died of Rh incompatibility in their parents; not even the doctors were aware of the diagnosis or treatment of the condition.

My work was in an exceptionally exciting and rewarding period in which to practice pediatrics. Year after year progress in diagnosis and the handling of cases were all about us. After the development of the various preventive shots, the next giant step in medicine was the coming of sulfa, penicillin, and the tetracyclines. The antibiotic era was in full swing. Then, after World War II came group practice, certification, and specialization. We had entered the modern age.

CONCLUSION

From the first day in my preceptorship at La Crosse I had been thrilled by the clinical side of the practice of medicine. To me the most fascinating aspect of the profession was that of a continuous learning process. I could never know all there was to learn about pediatrics as the volume of material on the subject was always being enriched, sometimes day by day. I learned from every case I saw and followed carefully, particularly from those where I had made a mistake or been stumped for a diagnosis. I read up avidly in the literature, textbooks, and periodicals. I attended lectures. I had formal and informal consultations with the most knowledgeable colleagues I could find. All-in-all it was a wonderful period of advancement in the pediatric field and in medical science in general. I still envy every young man or woman entering the profession and I still feel that the most satisfying life work anyone could ask for is that which I embraced on a spring evening over 50 years ago in La Crosse. ■

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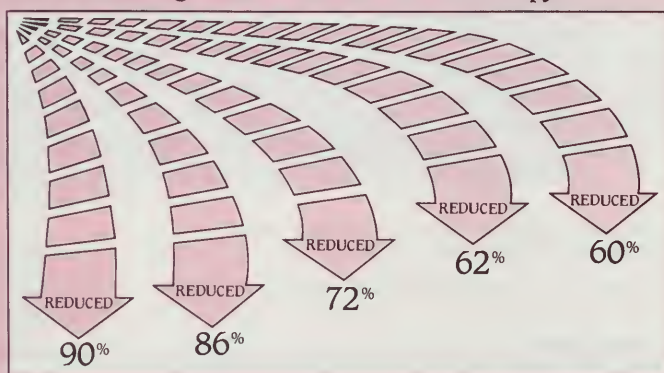


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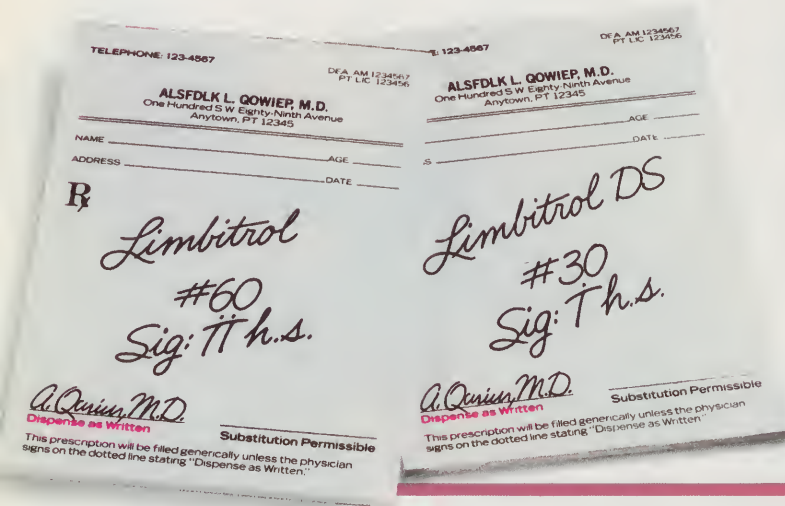
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Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (See Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

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Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

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A Pioneer Endocrinologist

SYLVIA F. BECKER, MD



Figure 1. Dr. Finkler in a horse-and-buggy ambulance.

On May 3, 1915, a startling article appeared in the Philadelphia newspaper, *The North American*: it declared a Russian peasant girl had obtained a position as a resident physician at the Philadelphia Polyclinic Hospital—the first time that the institution had accepted a woman for this position: Rita S. Finkler, MD.

Hardly a peasant, Ricka Sapiro, born in 1888, was raised in the town of Kherson, Russia, in the Ukraine, the “breadbasket of Russia,” an area where wheat was the main product. Her father was an engineer in a flour mill. Her mother came from a family of scholars and had been sent to a private girls’ school for the study of music and art. Ricka was the third of five children, two of whom died at an early age. Fortunately for her, her father was an unusual man for those days, who believed strongly in the education of women. Ricka was sent to the local “gymnasium,” a combination of primary and high school, from which she was graduated with the highest honors, obtaining a gold medal for her scholarship. Ambitious to further her education, she ap-

plied to the University of St. Petersburg, and to everyone’s astonishment, was accepted. It was almost unheard of for a young woman of her background to be accepted at any Russian university.

This was a time of great unrest in Russia; several of Ricka’s aunts and uncles were imprisoned because of their political activities. Always idealistic, Ricka decided to study law, hoping later to come to the aid of political prisoners. So intense was her interest in these causes that later articles about her erroneously reported that she too had been imprisoned. This was not true; she completed her studies at the University, but quickly realized that as a lawyer under the Czarist regime, she could accomplish nothing of value. With the death of her mother, whom she loved dearly, and the subsequent remarriage of her father, she was unhappy at home.

Sylvia F. Becker, MD, is a gynecologist/endocrinologist, and daughter of Dr. Finkler. Requests for reprints can be addressed to Dr. Becker, 340 East Northfield Road, Livingston, NJ 07039.

Disappointed and disillusioned, she decided to leave Russia.

Alone and without funds, Ricka Sapiro worked her way through Turkey, France, and England; by 1910, she had saved enough money through her labors to pay for her passage to the United States.

In the United States, Ricka visited her uncle and his family in Philadelphia, and there she was introduced to another Russian, a student at the Woman's Medical College of Pennsylvania. Her new friend was enthusiastic about medicine and persuaded Ricka to apply for admission to the school. After obtaining and presenting her credentials from St. Petersburg University and taking some chemistry courses, Ricka was admitted to the medical school in 1911. Working as a seamstress (a skill she had learned while in France), she was able both to support herself and study medicine. Indeed, at the end of her first year, she won an award for excellence in anatomy and then was given a scholarship at the medical school.

While at the Woman's Medical College, she met and married Samuel J. Finkler, a chemistry student at Pennsylvania State College. She was graduated in 1915 with high standing in her class. The place of women in medicine still was very controversial; at the graduation ceremony, Dr. Richard Cabot of Harvard, to the shock of the graduates, denigrated the role of women in the medical profession. The great Dr. William Osler of Johns Hopkins had praised the Woman's Medical College of Pennsylvania and the quality of its graduates.^{1,2}

MEDICAL CAREER

It was not easy for women to obtain internships. The Philadelphia Polyclinic Hospital was no exception in its negative policy toward women interns. Dr. Finkler's high grades on the admission examination, plus the enthusiastic backing of the dean and faculty of the medical school, persuaded the governing body of the hospital to accept her. This event was so unusual that several Philadelphia newspapers placed it on their front pages.

At the Polyclinic Hospital, the male interns were unkind. They resented the young woman and heaped double the normal workload upon her hoping to force her resignation. Never a quitter or a complainer, Dr. Finkler worked to the point of exhaustion. Finally, the director of the laboratory, Dr. John Koller, a kind and sympathetic man who later became a pioneer in immunological research, noticed her fatigue. He became her protector, and saw to it that her workload was reduced to normal.

While serving her internship, Dr. Finkler rode in a horse-and-buggy ambulance, and the hospital used her picture in its local newspaper campaign for a motorized ambulance.



Figure 2. Dr. Finkler as she appeared in 1942; she was a staff member of Newark Beth Israel Medical Center.

After completing her training at Polyclinic Hospital, Dr. Finkler obtained a position in Philadelphia with a private organization, the Child Federation, which later became the Department of Child Hygiene. Much of her work was in slum neighborhoods of poor immigrants from Russia, Poland, and Italy. She quickly learned to communicate in Italian and Polish, and was soon known as "Dotoressa Italiana" among the Italian population.

Among these ethnic groups only midwives were used in childbirth, and it was Dr. Finkler's assignment to followup with examinations of the mothers and babies after the deliveries. She began to develop a small private practice in the evenings, consisting mainly of obstetrics and gynecology. Deliveries were only done in patients' homes, and often were performed under the most difficult of circumstances for the patient and physician.

About this time, Samuel had obtained a position in New York City, and was finding it very difficult to commute between Philadelphia and New York. One of his friends in Newark told Samuel that he and his physician-wife were about to move out of town. The medical practice was offered to Dr. Finkler, and she decided to accept the offer for the sake of her husband; in 1919 they moved to Newark.

The office, with accompanying residential quarters, was located on High Street, across from the old Beth Israel Hospital. Dr. Finkler obtained a position

in pediatrics at that institution, and she proceeded to practice pediatrics, obstetrics, and gynecology. Soon she had become an extremely busy obstetrician and gynecologist. In 1921, amidst all this activity, she found time to have a daughter, Sylvia.

ENDOCRINOLOGY

Always seeking to increase her skills, Dr. Finkler participated in courses at both the Post Graduate and the Mt. Sinai Hospitals in New York City. Her avid reading of American and foreign medical journals brought a new specialty to her attention—endocrinology. She became fascinated by the research being done in this field, especially in Austria and Germany. Determined to learn more about it, she travelled to Germany to study with Dr. Bernhard Zondek, who, with Dr. Selmar Aschheim, was becoming famous for introducing the first hormonal test for pregnancy. She also studied with Dr. Herman Zondek, Bernhard's cousin, then chief of medicine and endocrinology in another large institution in Berlin.

When she returned to Newark, Dr. Finkler began to duplicate the experiments she had learned abroad, establishing a small endocrine laboratory at the Newark Beth Israel Hospital—the first such laboratory in New Jersey. Besides doing experimental animal work there, Dr. Finkler and her assistants performed the still-new Aschheim-Zondek test for pregnancy in this laboratory, which was for many years the only New Jersey laboratory able to perform the test. She was given the title “Associate in Biology,” but her work was considered part of the department of obstetrics and gynecology.

The Beth Israel Endocrine Laboratory became well-known in New Jersey because of Dr. Finkler's frequent lectures and her scientific papers in standard medical journals. One of her first published papers was in the September 1930 *Journal of the Medical Society of New Jersey* and was entitled “Early Diagnosis of Pregnancy by the Aschheim-Zondek's Reaction.”³ Another clinical paper in the same journal followed in 1931: “The Female Sex Hormone.”⁴ In 1933, the same journal published another of her papers, “Recent Advances in Clinical Study of Endocrine Disturbances in Women.”⁵ As New Jersey physicians became more aware of the new specialty, they began to refer patients to Dr. Finkler's department for the diagnosis and therapy of endocrine conditions. During her lifetime, Dr.

Finkler published 67 papers in many prestigious scientific journals.

Because of the increased volume of work, an Endocrine Service was established at the Newark Beth Israel Hospital in the 1930s. Inpatient and outpatient facilities became available—the first and only such service in New Jersey at that time. Dr. Finkler felt that the endocrine facility should be independent of any other department, but this required she receive senior attending status. There was opposition at first from several male members of the staff to assigning this status to a woman, but, finally, in 1939, after a close election, she was appointed the first female attending chief of staff of the Newark Beth Israel Hospital and the Director of the first endocrine department in New Jersey.

INTERESTS AND HONORS

Among Dr. Finkler's other accomplishments was her help in establishing the New Jersey branch of the American Women's Medical Association; her enthusiasm helped transform this nucleus into a large, thriving organization throughout the state. In addition, she formed a journal club for women physicians, which met monthly to exchange scientific and practical ideas; the group was highly supportive of all women physicians. During World War II, Dr. Finkler was associated with The Committee To Aid Distressed Women Physicians, a group who organized a drive to rescue displaced women physicians in Europe during the war and assist them in establishing medical practices in the United States.

In 1956, the New Jersey branch of the American Medical Women's Association honored Dr. Finkler by naming her Woman of the Year. In 1965, the Medical Society of New Jersey marked the occasion of her 50th year in the practice of medicine by awarding her its Golden Merit Award. In 1967, the Woman's Medical College of Pennsylvania made her the recipient of its Alumnae Achievement Award. The Newark Beth Israel Medical Center memorialized Dr. Finkler in 1969 in the formal dedication of the Rita S. Finkler Endocrine Clinic. Subsequently, the doctor's study was adorned by a bronze bust of Dr. Finkler and also was dedicated to her.

Dr. Finkler died in 1968 at the age of 80. Dr. Rita Finkler's battle against prejudice towards women in medicine broke down many barriers and acted as an inspiring example to the many women physicians who followed her. ■

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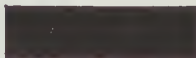
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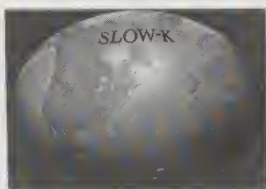
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1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.
2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure; hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control mild cases. In more severe cases supplementation with potassium salts may be indicated.

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Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

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In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS

General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients:

Patients should consider reminding the patient of the following:

To take each dose without crushing, chewing, or sucking the tablets.
To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.

To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions

Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

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The Life of Lena Edwards

LINDA JANET HOLMES, MPA



Figure 1. Lena Frances Edwards. From Lena Edwards Collection, Moorland-Spangarn Research Center, Howard University, Washington, DC.

Lena Frances Edwards, MD, is an outstanding figure among black women and among New Jersey's early 20th century female medical practitioners. Her towering presence largely can be attributed to the fact that she constantly was unleashing her energetic spirit in community service and in active commitment to social values. As a woman, she was in the forefront on social issues as varied as increasing the need for day care to that of cancer prevention. As a physician she advocated preventive health care, natural childbirth, patient involvement in health work, and holistic medicine.

During her lifetime, Dr. Edwards received frequent recognition and praise; various awards recognized her contributions to medicine, race rela-

tions, community service, and religious organizations: Woman of the Year, 1954, from the New Jersey Chapter of the American Medical Woman's Association; the Edward J. Ill Award from the Academy of Medicine of New Jersey; the Bronze Medal from the Cancer Society; the Woman of Achievement Award from *Jersey Journal*; the Medal of Freedom from President Johnson in 1964; and the Howard University Meritorious Life Award in 1984.

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Figure 2. President Johnson presenting Medal of Freedom Award to Lena Edwards, MD, 1964. From Lena Edwards Collection, Moorland-Spangarn Research Center, Howard University, Washington, DC.

BREAKING DOWN BARRIERS

As a black woman physician, Dr. Edwards was a trailblazer. When she began her practice in Jersey City in 1929, there already had been an established stream of black medical predecessors, both male and female, in the state and country. In fact, even during the slavery years, black doctors had practiced in this country and a black physician was known to have acquired a formal medical education as early as 1837.¹ Nevertheless, in the 1920s, when Dr. Edwards entered practice, there were a mere 65 black women physicians, according to the United States Census.² While Dr. Edwards certainly was not the first black female practitioner in the state, she was among the first black women in the entire nation to be Board certified as an obstetrician-gynecologist: in fact, there may have been only one other black woman Board certified before Dr. Edwards.³ She also was reported to be one of the first black women to gain admission to the International College of Surgeons. When fewer than 1 percent of the 5,000 members of the International College of Surgeons were female,³ Dr. Edwards was one of the earliest black female physicians to be elected to the College.⁴

In some ways, it is hard to envision the monumental nature of Dr. Edwards's accomplishments

compared to her actual physical appearance. She was small in stature, avoided high fashion, dressed plainly, and never wore makeup. For many years she wore her hair simply parted down the middle with pinned-up braids in the style of a schoolgirl. For Dr. Edwards, a treat of extravagance would be to sew fur on the collar of her suit.

Dr. Edwards also chose a personal lifestyle that was unembellished and uncomplicated. Much of her personal space was filled with expression of her deep religious devotion. Although she was a devout Catholic all her life, Dr. Edwards demonstrated how intense was her commitment to austerity when she took the voluntary vows of poverty and became a Lay Franciscan. When a pregnancy in her late childbearing years was plagued with medical complications, she vowed to attend mass daily. Blessed with a healthy outcome, she never violated her commitment to daily mass. Dr. Edwards maintained a home in Morris County for many years near a Catholic shrine, just for the purpose of family spiritual retreats. Apparently among her greatest personal joys were gardening and retreats that allowed time for appreciating nature.

EDUCATION

Lena was a high achiever. Similar to many other

middle-class black children, she attended Dunbar High School, the choice high school for black children in Washington, D.C. at that time, from which she graduated as class valedictorian. She attended Howard University and received her bachelor of science degree; immediately after graduation, Lena entered Howard University medical school and was the only female in her class that year.¹¹ Along with a medical education, Howard also provided the social environment for interaction with other expected achievers of her race. She married a classmate, John Madison, the day after graduation. Although Dr. Edwards's notions of childbearing and mothering responsibilities seemed to be highly congruent with the standard views of the Catholic Church, quite interestingly she never assumed her husband's surname but always remained Lena Frances Edwards.

ESTABLISHING A PRIVATE PRACTICE

After completing an internship at Freedman's Hospital in Washington, D.C., Dr. Edwards and her husband moved to the Lafayette section of Jersey City in 1925 to establish their respective medical practices. At a time when the schools in Washington, D.C. were segregated, their decision to move to Jersey City was partially motivated by their search for integrated parochial schools. Throughout her many years of medical and community service, Dr. Edwards would frequently crisscross racial and cultural categories in providing patient care and community service.

For a black woman, establishing a successful practice among white patients certainly was not the norm for the period; for the most part many early black female physicians were locked into providing care only for blacks who may have had limited financial resources. In this instance, the community in which Dr. Edwards worked was composed primarily of recently arrived Eastern European immigrants who were linked by their similar Roman Catholic backgrounds.

Among those families, Dr. Edwards soon developed her own "natural" set of clients. In the beginning, she and her husband literally shared the same office and waiting room space, alternating visits with patients. By the end of the first two years her husband had established a separate office in a neighboring house. Dr. Edwards said, "I guess my husband had more patients than I had at the beginning because it was hard for people to realize that this woman's a doctor. But fortunately I was in a neighborhood of the people from East Europe, like the Polish and the Slavish and what-not, and they were used to women, especially for maternity cases. They would come to me because they could talk freely to me. I built up a practice fairly well—very

well, as a matter of fact, in spite of the fact that I was having babies one behind the other."¹⁵

Despite the obvious intensity involved in establishing a medical practice and maintaining mothering responsibilities, Dr. Edwards extended herself into the arena of community service even in the early years. She often was called upon to speak at the YWCA and the local church on topics such as adolescent problems and even sex education. While always maintaining a broad-based humanitarian point of view, Dr. Edwards never failed to give special attention to the concerns of black people. In her very first year in Jersey City she organized a group of black college-educated women for the purpose of cultural exchange and to provide financial assistance and encouragement to young black women in college. Although the black women's club movement has a long history in this country, La Porte Cache, as it is called, was the first of its kind in Jersey City.⁶

By 1931, this lifelong pattern of integrating medical practice with community service and mothering was firmly established, but the opening of the Margaret Hague Maternity Hospital caused her professional life to shift dramatically. Until then, Dr. Edwards had attended the majority of the births at home, but with the opening of the Margaret Hague Maternity Hospital, her medical practice became concentrated in the hospital; moreover, the Hospital would provide opportunities for professional advancement. As a black woman, Dr. Edwards would find every professional advancing step challenged; but she remained steadfast and undaunted in her efforts to achieve. The strength gained from growing up in an environment where her independence was supported now would be tested; her deeply-rooted faith also would be challenged.

PERSEVERING IN THE PROFESSION

Dr. Edwards received an unsolicited appointment to the staff of obstetrics and gynecology at Margaret Hague Maternity Hospital. From the moment Dr. Edwards established a professional relationship with the Margaret Hague Maternity Hospital, it seemed that her gender, race, and inherent self-pride, drive, and refusal to take a posture of complacent acceptancy clashed with the empowered white male medical structure. She was in the hospital only a short period of time when she was told her presence on the staff was a problem. Nevertheless, she decided to pursue a residency in obstetrics and gynecology there; Dr. Edwards said that the critical moment in this decision actually came at a point of personal frustration when she believed that her inability to make decisions on medical management was compromising the welfare of her patients. "After that I decided I'm going to get a residency so I can

be assistant to the chief and determine myself what's going to happen to my patients."⁵ On repeated occasions her application was rejected. At one point it was suggested that she pursue a residency at New York's Harlem Hospital, but she continuously re-applied to Margaret Hague Hospital. In a fiery verbal protest in her usual blunt style, Dr. Edwards lashed out at the decision makers: "I've been coming here every year with my application to be a resident. I am now 44 years old, and I am going to keep on coming until I have to come in a wheelchair. You're not God, you know, and you can't tie my hands until you have given me the opportunity to use them."⁶ Finally, in 1945, she was accepted as a resident at the Margaret Hague Maternity Hospital.

For Dr. Edwards, the burdens of gender outweighed the handicaps of race; she was convinced that male opposition to females in any aspect of surgical practice would ultimately be more difficult to overcome than racial barriers. Perhaps she was far better equipped to withstand the expected racial prejudices as facts of life: issues of sexual discrimination may have received less formal attention when she was growing up than racial ones. In an interview in 1947 she discussed the problem: "Men resent women in surgery, and also in obstetrics because it is so close to surgery, so that it is still something of a handicap in obstetrics to be a woman—even today." She added, "In my case, racial barriers have arisen too, but I do not feel that being a Negro doctor has ever been so much a handicap as being a woman doctor."⁷

Dr. Edwards completed her residency in 1946, but again she faced resistance in her efforts to pursue the next logical step in the process of professional advancement: taking the National Boards in obstetrics and gynecology. After finally receiving the necessary endorsement to take the examination, she immediately was reminded upon entering the Shoreham Hotel in Washington, the site of the oral examination, that she was a black physician who was subject to the prevailing practices of segregation. She was ordered to take the service elevator. Not surprisingly, however, the always self-confident and persuasive Dr. Edwards convinced the elevator operator that she was entitled to the same elevator service as the other physicians. As a result of passing the Board examination, Dr. Edwards entered the annals of medical history as one of the first Board-certified black female obstetrician-gynecologists in the country. In 1953, she became a Fellow of the International College of Surgeons; moreover, in 1971 the U.S. Section of the College informed her that she would remain an active member without further dues commitments.

Even after becoming Board certified, Dr. Ed-



Figure 3. Dr. Edwards at a meeting of the International College of Surgeons. Dr. Edwards was one of the first women elected to the College. From Lena Edwards Collection, Moorland-Spingarn Research Center, Howard University, Washington, DC.

wards' struggles for full professional recognition within the Hospital were not over. A letter, apparently written while she was on call at the Hospital, but perhaps never sent, reflected the depths of her frustrations. Although she seldom chose to focus on frustrations, like others in similar situations, she sometimes grew weary:

For 25 years I have enjoyed a successful practice in Hudson County from the standpoint of patient-physician relationships and the privileges enjoyed at the medical center. But the greatest love that I have in my profession has been boiled down to the love of faithful, untiring service to my patients under the most humiliating and nerve-racking circumstances. But for the fact that I have a great respect for my pledge to the Oath of Hippocrates and an ardent desire to practice my profession as outlined in the Physician's Prayer, I would resign from the obstetrical staff and practice only gyn[sic]. The fact that I am a certified specialist who is trained in the specialty has made no difference in my status. I am the only certified obstetrician in the county without privileges in the Margaret Hague Maternity Center, albeit for three years I have met all qualifications except possibly race, sex, and age. There have been several appointments made while I have been consistently ignored. It is not my custom to beg for anything nor do I ask favors of anyone when it comes to my work. I know only the hard way, constant study, long hours, and efficient service.⁸

Ultimately, Dr. Edwards was appointed an Assistant Attending at the Margaret Hague Maternity Hospital; she remained there until 1954, when she



Figure 4. Dr. Edwards and friends from Margaret Hague Maternity Hospital. From Lena Edwards Collection, Moorland-Spingarn Research Center, Howard University, Washington, DC.

decided to spend some years teaching at Howard University in Washington, D.C. At her fated departure from Jersey City, it was reported she had delivered over 5,000 babies during her years of service in that community. Five years later, she went to Hereford, Texas, where she dedicated herself to work with Hispanic migrants and where she built a small maternity hospital. Dr. Edwards received the Medal of Freedom because of the personal sacrifice required and the achievements gained during her five years of mission work in Hereford.

FULFILLING THE MISSION

Throughout her life Dr. Edwards never grew tired of caring. During her senior years her work was characteristically vibrant. In fact, along with the wonder in the longevity of her work, there is an outstanding quality in the consistency of her work—never wavering from certain basic social values. As might be expected, as she grew older in no way did the frailties of her body defeat her; they only challenged her.

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The final relinquishing of her medical practice did not seem particularly difficult. But even when Dr. Edwards ended her formal practice as a physician she never ceased offering advice about diet and exercise. She chastised those dependent on medications and was known as a physician who threw medicines out of a patient's window when she believed they were useless.⁹

In her last years, however, she was making plans to return to Jersey City to live, but those plans never materialized. Her daughter recalled, "She must have been on her way to the bathroom and just decided it was time to lay down and die. She didn't appear to have fallen. It rained the night before quite heavily, a major storm between 7 and 11 P.M. I called a number of times Tuesday during the evening, but didn't get an answer. I thought she was involved in one of her community activities. She always said she wanted to die with her boots on."¹⁰

And, indeed, when she died Lena Frances Edwards was still in the midst of doing so many of the things in which she fervently believed. ■

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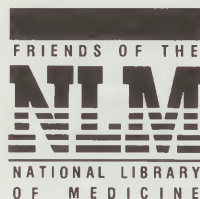


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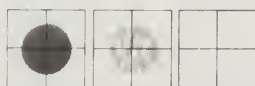


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The Story of Sarah Mackintosh

GERALDINE HUTNER, MA



Figure 1. Sarah's final resting place.

Photo: Frank Cecala

On October 7, 1872, Sarah Fonda Mackintosh, MD, became the first woman member of the Passaic District Medical Society,¹ and eight months later, in June 1873, made further history by becoming the first woman inducted into a state medical society—the Medical Society of New Jersey, the oldest such society in the United States.²

BIOGRAPHY

Sarah Mackintosh, nee Apfonda, was born in New York City in January 1836 of a prominent and well-to-do family.³ Her father, a born-and-bred New Yorker, was a major in the Army; and her mother, though originally from New Hampshire, lived in New York for a number of years. Not much is known

about Sarah Apfonda's early years, until, at the age of 33, she entered the Woman's Medical College of the New York Infirmary at 128 Second Avenue in New York City.⁴

The Woman's Medical College of the New York Infirmary had been founded by Elizabeth Blackwell and her sister Emily in 1868 because, as Elizabeth put it, "The practice of medicine by women no longer is a doubtful, but a settled thing. But there is not in the whole extent of our country a single medical school where women can obtain a good medical education."⁴

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Sarah Apfonda was one of nine students in the school's class of 1872. During her first year, she studied anatomy, physiology, materia medica, and chemistry; and there was practical work in pharmacy and in the anatomy rooms. In her second year there was additional class work in medicine, surgery, hygiene, and obstetrics. Small group bedside instruction, as well as a residency program at the school's Infirmary, also were available to second-year students. During their third year, students performed practical work and were expected to make case reports for their teachers. All students prepared a thesis paper as a final project for the degree of Doctor of Medicine; Sarah's topic was syphilis. When she had finished, Sarah received a diploma from the College Board of Examiners as well as her medical degree.

In 1870, before she graduated from medical school, Sarah married James Hetherington Mackintosh of Paterson, a pharmacist attending medical school at Bellevue Hospital Medical College in New York City, from which he received his medical degree in 1872. He had been born in England of Scottish parents and had emigrated to the United States in 1850; he became a citizen 33 years later. Sarah and James had three children: James Alexander (1872-1957); Sarah F. (1873-1956); and Lillith, who died in infancy.

In 1872, the Drs. Mackintosh started a practice together in Paterson and were speedily awarded membership in the Passaic District Medical Society. In 1875, they opened a private practice in a combined home/office at 136 Carroll Street; in 1886, they moved to 194 Carroll Street, where their office hours were 8:30-9:30 A.M.; 1-2 P.M.; and 6:30-8:30 P.M.⁵ In 1887, the Mackintosh family again relocated—to Asbury Park, where they bought a house/office at 515 Third Avenue. (At that time, living with them was Sarah's father-in-law, James F., a widower, who had come to the United States with his son in 1850; a house servant, Pinkie L. Jones, a single, 23-year-old black woman from Virginia; and daughter Sarah, who was unmarried and remained at home with her parents).^{6,7} Later, the family lived at West Fifth Avenue, at which place Sarah died in 1903.

Sarah joined the Monmouth County Medical Society soon after moving to Asbury Park; she also was affiliated with the Monmouth Medical Center about the same time, and remained an active staff member until her death.

Sarah Fonda Mackintosh, MD, died at home in Asbury Park on October 19, 1903, and was buried in the family plot in Cedarlawn Cemetery in Paterson.* Her tombstone reads "A true wife, a devoted mother, and a generous friend of the poor." Obituaries appeared in the *Asbury Park Journal* on

October 20, 1903, and October 30, 1903,^{3,8} and included the following statements:

Dr. Sarah Mackintosh, who died at her home on West Fifth Avenue yesterday, was probably one of the best known women in Asbury Park . . . [She] did many kind and graceful acts of charity. She was always ready to give when called upon and did a great deal for the poor people of this city and surrounding towns in a quiet and unostentatious way. Mrs. Mackintosh was loved and highly esteemed by everyone who knew her . . .

The later notice pointed out that "Dr. Sarah Mackintosh rated high in the medical profession" and emphasized that she had been the first woman member of the Passaic County Medical Society.

MEDICAL EDUCATION FOR WOMEN

Elizabeth Blackwell, who founded the medical school Sarah attended, was the first woman to receive a medical degree in the United States, which she obtained from Geneva College of Medicine in upstate New York under unusual circumstances. After studying with Dr. Joseph Warrington of Philadelphia, Elizabeth applied for admission to Geneva, an all-male school. The Dean felt the students would not tolerate the presence of a woman and so let them vote on Elizabeth's application. To his surprise, the student body voted to accept the request, stating "that the application of Elizabeth Blackwell to become a member of our class meets our entire approbation; and in extending our unanimous invitation we pledge ourselves that no conduct of ours shall cause her to regret her attendance at this institution."¹¹ Although the students did not live up to this pledge, Elizabeth persisted, and on January 23, 1894, duly received a degree of Doctor of Medicine.

Elizabeth Blackwell soon realized the need for a hospital in which women physicians could practice, and so with her physician-sister Emily, she helped to raise enough funds by 1857 to establish the New York Infirmary for Women and Children in New York City (now Beekman Hospital); 11 years later, with the approval of colleagues and workers, Elizabeth and Emily Blackwell fought to have the Infirmary's charter amended to allow it "to grant and confer the title of Doctor of Medicine."⁴ The Woman's Medical College of the New York Infirmary opened in November 1868 with a class of 17 students, 11 faculty members, and an 8-member Board of Examiners. The records stated, "A good general education was required for admission. Before receiving their diplomas, the candidates were asked to present a certificate from a clergyman, physician, or other responsible person, testifying to their moral character. A full year's course of lectures cost \$105,



Figure 2. Sarah Mackintosh's tombstone in Cedarlawn Cemetery.

(Photo: Frank Cecala)

plus \$5 for the Demonstrator's fee. Graduation fee was \$30 and a Matriculation ticket cost \$5."¹¹ The school had many eminent alumni and lasted until 1899, closing only when coeducation for medicine seemed assured.

There are no diaries or letters explaining Sarah Mackintosh's reasons for wanting to pursue a medical career, although we perhaps can assess her reasons by looking at the industrial and sociological changes taking place in 19th century America:

It was the social definition of woman's role in the 19th century that made more and more middle class women comfortable with the idea of studying medicine Women doctors belong to that group among 19th century women that historians have labeled domestic feminists. They viewed their campaign to study and practice medicine as part of a larger effort to adapt traditional concepts of womanhood to the demands of an unstable, complex, and rapidly

industrializing society. This redefinition explicitly called for a more intensive role within the family for all women and implicitly demanded a more comprehensive role for at least some women in society at large. Rarely did this early generation of women physicians challenge the cult of domesticity. They were genuinely comfortable with the concept of separate sexual spheres, because it allowed them to argue that women, by virtue of their special skills at nurturance, had a role in medicine that could compensate for, and be complimentary to, the role and achievements of men.⁹

Sarah Mackintosh probably was drawn to medicine as were other women; as a member of the middle class; moreover, she had the means to support herself and to reach her goal.^{9,12}

MEDICAL SOCIETIES

The need to join a medical society was as impor-

tant in the 19th and early 20th centuries as it is today. "It was in medical societies that physicians could meet to exchange information on medical ideas, techniques, and innovations. American medical societies were involved with medical licensing, setting professional standards, establishing fees, controlling schedules, and generally standardizing their profession. Through medical societies, physicians received case referrals and recommendations to hospital and other professional appointments. Indeed by the late 19th century, medical society membership was a virtual prerequisite for most hospital affiliations. . . . Membership in medical societies accorded its members status, economic and professional advantages, and consciously sought to establish inside and outside groups within the profession."⁹

In the 1850s, women began applying for membership in medical societies, specifically the Massachusetts State and the Philadelphia County Medical Societies, but were excluded from these organizations until the 1880s. The American Medical Association turned down all women applicants; female members were not admitted until 1915. Records show that Dr. Anna Lukens was admitted as a member of the Montgomery County, Pennsylvania, Medical Society in 1870, but not to the state medical society;^{9,12} hence, Sarah F. Mackintosh, MD, inducted into the Medical Society of New Jersey in 1873, was the first woman member of a state medical society in the United States.

In 1864, the revised bylaws of the Medical Society of New Jersey stated that all members must have completed training and passed an examination before applying to the District Society for membership,¹³ and it was under these rules that Sarah Mackintosh in 1872 applied for membership in the Passaic District Medical Society and was accepted. (This Society had been organized in 1844; by 1872, there were 28 members.) The minutes from the October 1872 meeting of the Passaic District Medical Society merely listed 5 new members, including Sarah and her husband James. The next year, in June 1873, Sarah's name was similarly added to the roll call of new members of the 397-member Medical Society of New Jersey—without any special recognitions or accolades upon becoming the first woman member of the Medical Society.

Dr. Mackintosh took her memberships in these societies seriously. If it seems unusual that she received no special recognition upon her acceptance in the fabric of the Medical Society, it is even more unusual that in 1874, soon after her induction, she presented a paper to the membership—the first woman to make a presentation¹⁴ to this all-male organization:

Chloral Hydrate in Labor

by Sarah F. Mackintosh, MD

Chloral hydrate, in the tedious first stage of labor, particularly in primipara, is a most valuable agent. From my own experience, in its use in the obstetric wards of the New York Infirmary, I am inclined to call it the most valuable agent we possess.

Given in 20 gram doses, it moderated the pain, hastens dilatation, and leaves the patient in so comfortable a state that she will frequently doze off between the pains, and, after delivery, almost immediately fall into a refreshing sleep. Without producing the complete insensibility which accompanies the use of chloroform or ether, and which is so often so alarming to ignorant attendants, and also without being supplemented by nausea or vomiting, it has, in ordinary cases, nearly all the advantages which attend the use of these anaesthetics.

As for my own practice, I never attend an obstetric case without carrying my chloral with me.

In 1876, Sarah Mackintosh became the County Reporter for the District Medical Society of Passaic. Reporters were expected to attend Annual Meetings, but Sarah was absent from the 1876 meeting. Instead she sent her communication¹⁵ with James, who was a delegate at the 110th Annual Meeting of the Medical Society of New Jersey in Congress Hall, Cape May City, May 23, 1876:

To Chairman of Standing Committee, &c.:

In accordance with your request, calling for opinions as to the value of topical remedies in malignant sore throat, and also to the cases in which calomel is considered the most beneficial, the reporter has sent notes to the different physicians composing our District Medical Society, to which but one, Dr. A.W. Rogers has responded [After this lengthy two-page report, Dr. Mackintosh continues:] During the past year Paterson has been visited by scarlatine and diphtheria, and by a few cases of variola; the latter, however, was pretty thoroughly isolated and quickly controlled.

Of diphtheria there have been many cases, with quite a large percentage of deaths. The treatment which in the hands of your reporter has been most successful, is that which is directed to the disease as a constitutional one entirely, and, as such, to be treated by *general* rather than *local*, remedies. Of these, the tincture of the chloride of iron and potassium chlorate, with stimulants and alimentation almost ad libitum, have appeared to yield the best results.

Scarlatine has presented about its usual variety of type; in some instances being so malignant as to overpower by its poison in a short time; in others so mild as scarcely to call for medicine at all.

In March and April, 1876, the epidemic of influenza which spread so extensively through the Middle States, prevailed to quite an extent here, but was generally more annoying than dangerous.

Our District Society is in a flourishing condition, numbering over 30 members.

Since the sending of the last report, our President, Dr. Orson Barnes, has been removed by death. After a lingering illness, he died July 23, 1875, in his 46th year, sincerely respected by his associates in the profession.

Over the next two years there were no reports from the Passaic District presented at the Medical Society's Annual Meeting. The report for 1879, written by Calvin Terriberry, MD, County Reporter, was six pages in length; in it he quotes Dr. Sarah Mackintosh on the use of pessaries in uterine displacements: "As palliatives, rendering the patient in some cases more comfortable, I have found them useful; as curative agents except in recent cases, the contrary."¹⁶

As soon as she was settled in Asbury Park, Dr. Mackintosh became a member of the Monmouth District Medical Society, which had been organized in June 1816. In 1888, when she joined it, there were 45 members in the District Society and 1,250 members in the State Society. Although she remained a member of the Monmouth County District until her death, there is no information on Sarah's contributions to it.

Sarah Mackintosh belonged to other societies. In 1878, she became a member of the Association for

the Advancement of Medical Education for Women; her name, along with that of Dr. Elizabeth Blackwell, appears on a report issued from a meeting of this group which took place in Union Hall, New York City.

In addition, Sarah was elected Secretary of Ladies Hospital in Paterson in 1873—one of four officers. Ladies Hospital, first known as The Hospital of the Ladies Association, was created in 1871 by the women of the Paterson Benevolent Society. A public institution, which became Paterson General Hospital in 1887 (and today Wayne General Hospital), opened to accommodate the growing need for hospital facilities in booming Paterson. The hospital was considered "a ladies enterprise, the ladies alone would have the management of it."^{17,18}

FINDINGS

Most of Sarah Apfonda Mackintosh's life is buried with her and her family and friends. Her personal feelings and emotions most likely will remain an enigma. What made her attend medical school and become a physician we may never know. It would appear, though, that she was a feminist in her own right, although, like many of the woman physicians both of her day and today, she combined the roles of wife and mother with the demanding role of physician. She was an active supporter of her family and medical community and gave of herself emotionally, financially, and socially. Her active role as a physician in Paterson and Asbury Park prove she was able to combine the traditional roles expected of 19th century women with the nontraditional role of doctor. Even more, Sarah Mackintosh, by finding her rightful place along her male colleagues in the Medical Society of New Jersey, was able to break ground for the women who came after her. By the time she died in 1903, there were over 20 women members of the Medical Society of New Jersey. ■

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18. New York Infirmary: Alumni Association Report, 1892.

*The plot had originally been owned by Sarah's mother, Mary Apfonda, and was bought by Sarah's husband James in 1900.

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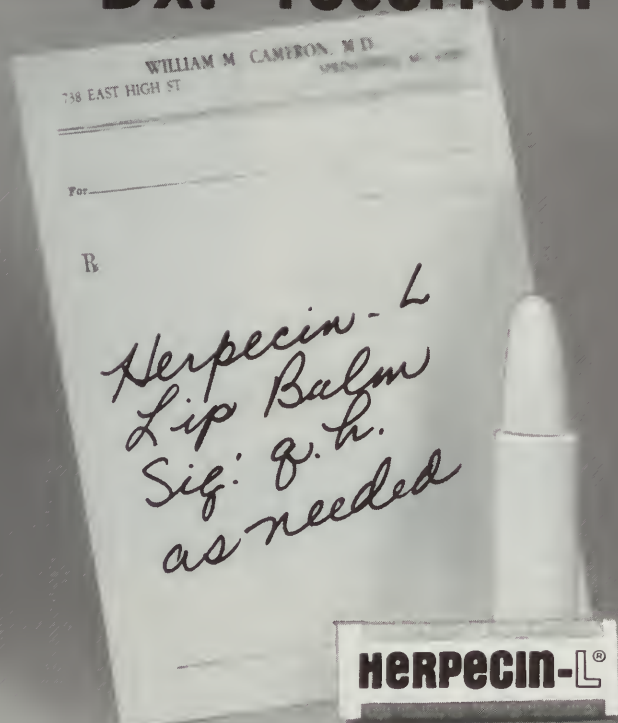
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DOCTORS' NOTEBOOK

Trustees' Minutes; UMDNJ Notes; Physicians Seeking Location in New Jersey

Trustees' Minutes March 20, 1988

A regular meeting of the Board of Trustees was held on March 20, 1988, at the Executive Offices in Lawrenceville. A detailed report is on file with the secretary of your county society. A summary of significant actions follows:

Report of the President . . .

1. Meeting and Conferences . . . Noted that Dr. Carnes attended nine meetings and conferences in February and March.

2. Occupational-Related Problems . . . Received notice that MSNJ will participate in a Department of Health program to identify individuals with occupational-related problems.

3. Legislative Update . . . Heard a legislative update from Clark Martin, MSNJ legislative representative, concerning: a mandatory assignment bill (A-2305); a public hearing to address mental health issues; Assembly passage of A-1591 (Licensing of Health Care Providers by Agency Action); the concept of licensing reform is being prepared in bill form; and, the Senate Committee on Institutions, Health, and Welfare will hear S-2091 (Conflict of Interest) requiring physicians to reveal whether they have a financial interest in any

type of service to which they refer patients.

4. JEMPAC Activities . . . Noted the following items of interest: Senator Frank Lautenberg and Pete Dawkins, Republican candidate for the U.S. Senate, were invited to attend the JEMPAC Wine and Cheese Reception at the Annual Meeting; JEMPAC will be represented at the 1988 Third Annual Republican Speaker's Dinner-Dance; and Assemblyman Chuck Hardwick will receive the AMNJ 1988 Citizen's Award to be presented at the Awards Dinner at the Chanticleer on May 25, 1988.

Commissioner of Health . . . Welcomed State Commissioner of Health, Molly Joel Coye, M.D., M.P.H., and Deputy Commissioner of Health, David Knowlton; Dr. Coye expressed her interest in learning the concerns of MSNJ and working to achieve a mutually acceptable resolution to issues.

Report of Executive Director . . .

1. MSNJ Paid Membership . . . Noted there are 6,107 paid memberships at the end of February 1988.

2. Glushakow versus Zavodnick . . . Noted that MSNJ filed an amicus brief in the appeal of this case, supporting the position of Dr. Glushakow; the case involved a guarantee for payment of physician's fee which was disregarded by the patient's attorney.

3. In re Brayshaw . . . Approved MSNJ's entering the case amicus, with the understanding that the defendants will be accorded the same rights as defendants in civil liability cases, namely: that they be entitled to complete discovery of that which the state possesses in terms of evidence; that they have the right to receive the reports of the state's expert witnesses; and that they have the right to depose those witnesses.

4. Emeritus Status . . . Voted unanimously to adopt the policy whereby age 65 is to be the normal retirement age for nomination to emeritus membership status. Also, directed that the Committee on Revision of Constitution and Bylaws also review the requirements for emeritus membership status and report back to the Board.

5. Federation of Licensing Boards Disciplinary Report . . . Received for information a copy of the Feder-

ation of Licensing Board summary of disciplinary actions reported for 1986 by state boards, and noted that the article reflected quite unfavorably on New Jersey.

UMDNJ . . .

1. Children's Hospital Proposed . . . Noted that a certificate of need is being sought for the location of a Children's Hospital on the Newark campus of UMDNJ.

2. "Top 25" Program . . . Received a report on the two-year study conducted by a national panel to meet the "Top 25" challenge of Governor Kean; two recommendations include reduction of tuition to one-quarter of its current sum and development of a scholarship program.

NJ Hospital Association . . .

1. Nursing Shortage Workplan . . . Noted that The Nursing Resource Center was inaugurated in February.

2. Medical Waste Disposal . . . Received information from Mr. Scibetta that a bill addressing the problem of medical waste is being drafted by Senator John Russo.

3. Reinsurance Association Surcharge . . . Was informed that the NJHA Board soon will develop an official posture on the issue of this surcharge.

4. Hospital Information Network . . . Noted that NJHA's Hospital Information Network has been sold to a Hospital Satellite Network in California.

MSNJ Auxiliary . . .

1. Continuing the Fight Against Drug Abuse . . . Approved the following resolution:

Resolved, that this principle of "no use of any illegal drug and no illegal use of any legal drug" shall be accepted by the American Medical Association Auxiliary in their quest for a drug-free society; and be it further

Resolved, that this principle be clearly communicated to our communities and families through educational programs, legislative actions, publications, and the use of the media on a national, state, and county level; and be it further

Resolved, that the state and county auxiliaries be encouraged to continue and revitalize programs and projects to promote drug awareness, education, and prevention; and be it further

Resolved, that these programs be undertaken with the approval of, and in coop-

eration with, the corresponding state and county medical societies/associations.

2. Auxiliary Support by Spouses . . . Carried the motion that physician members of MSNJ encourage spouses to become members of the MSNJ Auxiliary and to back its physician-focused activities.

Committee on Medicaid . . . Adopted the following position:

The Medical Society of New Jersey recognizes the Garden State Health Plan (GSHP) as a new, innovative, and potentially viable method of delivering quality health care to Medicaid recipients. The Medical Society appreciates the decision to implement the plan on a voluntary basis for patients and physicians.

In order to maximize the potential of the GSHP, and at the same time assure that Medicaid recipients (90 percent of whom will not be served by the GSHP format during the next three years) have access to quality health care, it is essential that simultaneous with implementation of the GSHP, the current physician fee schedule be increased to a minimum of 100 percent.

The government of the state of New Jersey must take notice that a 100 percent increase in physician fees will be the first recognizable adjustment in 18 years. At the same time, it still will produce reimbursement below that currently allowed by Medicare. This adjustment is necessary to prevent a service availability crisis in the Medicaid program.

Committee on Utilization Review Systems . . . Approved the following recommendation and directed the AMA Delegation to prepare a resolution for submission to the AMA House of Delegates in June:

That the Medical Society of New Jersey address the issue of socioeconomic hospital admissions, and that a solution be sought via legislative means.

Committee on Biomedical Ethics . . . Approved the following recommendation:

That MSNJ send a letter to the Commission on Legal and Ethical Problems in the Delivery of Health Care endorsing the concept of including the artificial administration of nutrition and hydration in the definition of life-sustaining treatment that can ethically be withdrawn from permanently comatose, vegetative patients.

Task Force on AIDS . . . Noted the organizational meeting of the Task Force on AIDS was held and topics

discussed included: policy on the testing of HIV positive patients, health care personnel who are HIV positive, and development of an AIDS program for the MSNJ Annual Meeting.

Committee on Senior Citizens . . . Noted the final report on the Senior Citizen Courtesy Program soon will be available and the April Senior Citizens Forum was cancelled because of a lack of registration.

Unfinished Business . . .

1. Verification of Financial Hardship . . . Filed a communication from the Morris County Medical Society advising MSNJ that any Morris County physician requesting exemption from the \$100 assessment should be granted the exemption.

2. Atlantic County Medical Society . . . Noted that the Tierno versus Atlantic County Medical Society lawsuit has been settled.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

UMDNJ's investment in "cutting-edge" medicine paid a dividend last month when University Hospital be-

came the site of the first known birth in the northeastern United States of a baby conceived with a donated egg. The New Jersey mother (who requested anonymity) and her baby girl are home and both are doing well.

The event, which gained widespread media attention, was the second major breakthrough recorded by our Center for Fertility and Reproductive Medicine, which is based at the hospital. Just a year ago, the Center announced its first pregnancy achieved via a donor egg.

In the recent case, the woman was unable to produce eggs of her own because of premature ovarian failure. The pregnancy was achieved by using another woman's ovum, or egg, and two innovative techniques originated at the Center.

The Center is one of the few institutions in the world with a successful egg donation program. There is no worldwide registry of pregnancies or births through egg donation, but the number is believed to be quite small.

The donor egg program is a form of in vitro fertilization (IVF), which has been used to produce babies for nearly a decade. Normally, the IVF procedure involves surgically remov-

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ing the would-be mother's own eggs from her ovaries, fertilizing the eggs with her husband's sperm in a "test tube," and then placing the fertilized embryos into the woman's uterus. This procedure can be successful for women who have blocked or damaged fallopian tubes or who have endometriosis or a partner with low sperm count. But if a woman's ovaries do not produce eggs, she can become pregnant only through egg donation. Such a condition can occur due to premature ovarian failure; women born without ovaries; and women whose ovarian function has been destroyed by, for example, radiation therapy for cancer.

Six pregnancies of eight attempts have been achieved thus far. The Center's first successful implantation, and one other, ended in miscarriage; three other women still are pregnant. Miscarriage occurs in about 25 percent of all IVF pregnancies, and in 15 to 20 percent of all pregnancies.

The UMDNJ program only uses eggs from known donors and there is no exchange of money. Two innovative donor egg procedures are employed. One involves retrieving the egg from the donor without surgery by using a transvaginal ultrasound probe. In addition, to make the recipient's uterus have the right hormone levels to accept the fertilized egg, estrogen is supplied via patches applied to the skin. This latter methodology was designed by Dominique de Ziegler, M.D., of our faculty, who manages each egg donation cycle.

While ovulation is being stimulated in one woman, the other is receiving hormones to prepare her uterus for pregnancy. Instead of administering estrogen through pills—the procedure used in previous attempts—estrogen patches are applied to the skin to deliver a reliably measurable amount of the hormone to the blood. This procedure causes less nausea for the patient and bypasses the liver, which eliminates an unpredictable amount of estrogen when administered through pills.

The Center's egg retrieval technique is significant because, previously, general anesthesia was required to retrieve the donor eggs through an abdominal incision. The ultrasound probe enters through the vagina and the needle crosses the peritoneal cavity to reach the

ovary. The physician views the procedure on the ultrasound screen to guide the retrieval needle to the ovary to retrieve the eggs.

Actual fertilization of the donor egg takes place in the same in vitro manner as fertilizations using a woman's own egg. The usual technique is to transfer up to four embryos to increase the likelihood of pregnancy. Any remaining nonimplanted embryos are frozen for possible future transfer to the same patient.

The Center's team of specialists is led by Gerson Weiss, M.D., professor and chairman of obstetrics and gynecology at UMDNJ-New Jersey Medical School and Cecilia Schmidt, M.D., Center director.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY—Jerry Michael Shier, M.D., 11546 February Cir., Apt. 202, Silver Spring, MD 20904. UMDNJ 1982. Also, clinical immunology. Board eligible. Board certified (PED). Group, partnership, solo. Available July 1988.

ANESTHESIOLOGY—Kenneth Lum, M.D., 7240 Twin Eagle Lane, Fort Myers, FL 33912. Downstate 1985. Board eligible. Available.

Steven H. Ressler, M.D., 424 North Midland Ave., Saddlebrook, NJ 07662. Guadalajara 1982. Board eligible. Group or fee-for-service. Available July 1988.

CARDIOLOGY—Donald G. Rubenstein, M.D., 1037 3rd St., #303, Santa Monica, CA 90403. Louisiana 1980. Board eligible. Group or partnership. Available August 1988.

ENDOCRINOLOGY—Robert P. Castellucci, M.D., 3509 Kensington Ave., #3, Richmond, VA 23221. St. George's 1982. Board eligible. Partnership or group. Available September 1988.

Gerald B. Miele, M.D., 110 Fleet Pl., Mineola, NY 11501. Rush 1983. Also, internal medicine. Board eligible. Partnership, group, solo. Available July 1988.

FAMILY MEDICINE—Roy Berkowitz-Shelton, M.D., 132 Grove Pk., Ft. Dix,

NJ 08640. Georgetown 1981. Board certified. Partnership. Available.

Serge I. Kaftal, M.D., 30 South Auten Ave., Somerville, NJ 08876. Lodz (Poland) 1980. Board eligible. Solo, partnership, group. Available November 1988.

GASTROENTEROLOGY—Anil Agarwal, M.D., 18 Maltese Dr., Fair Lawn, NJ 07410. LLRM Medical (India) 1979. Also, internal medicine. Board eligible. Board certified (IM). Available July 1988.

David Rosenbock, M.D., 5 Riggs Pl., West Orange, NJ 07052. UMDNJ. Board eligible. Board certified (IM). Group, partnership, solo. Available July 1988.

INTERNAL MEDICINE—Anil Agarwal, M.D., 18 Maltese Dr., Fair Lawn, NJ 07410. LLRM Medical (India) 1979. Also, gastroenterology. Board certified. Available July 1988.

Paul R. Axelrad, M.D., 666 Ninth St., Lakewood, NJ 08701. St. George's University 1985. Methodist Hospital. Board eligible. Group or partnership. Available July 1988.

Marc Hanfling, D.O., 26 Glen Lane, Cherry Hill, NJ 08002. New York College 1981. Also, cardiology. Board certified. Board eligible (CARD). Group, partnership, solo. Available.

Peter Kuzmick, D.O., 62 Diamond Ave., Fort Rucker, AL 36362. Kansas City 1980. Board certified. Group or partnership. Available July 1988.

Gerald B. Miele, M.D., 110 Fleet Pl., Mineola, NY 11501. Rush 1983. Also, endocrinology. Board eligible. Partnership, group, solo. Available July 1988.

Edward C. Phillips, M.D., 24 Walnut St., Summit, NJ 07901. Downstate 1984. Board eligible. Group, partnership, solo. Available July 1988.

Joseph T. Wayne, M.D., 106 Elmwood Dr., Prudenville, MI 48651. SUNY-Buffalo 1982. Board eligible. Board certified (PED). Also, pediatrics. Group, partnership, academic. Available October 1988.

PEDIATRICS—Linda York-Chance, M.D., 435 East 70th St., New York, NY 10021. Connecticut 1985. Board eligible. Clinic or emergency room. Available July 1988.

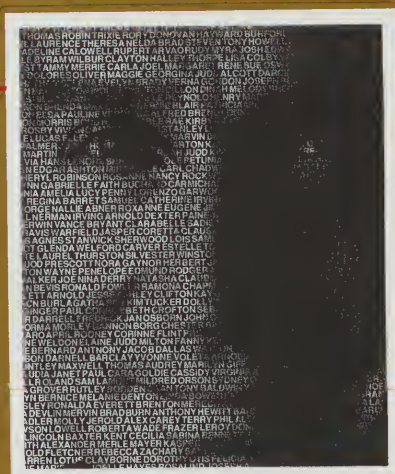
Joseph T. Wayne, M.D., 106 Elmwood Dr., Prudenville, MI 48651. SUNY-Buffalo 1982. Also, internal medicine. Board certified. Board eligible (IM). Group, partnership, academic. Available October 1988.

PSYCHIATRY—Jozsef Telkes, M.D., c/o John Black, 3901 Crosswicks-Hamilton Square Rd., Robbinsville, NJ 08691. Pecs (Hungary) 1978. Board certified. Group or research. Available September 1988.

SURGERY—James H. Frost, M.D., 655 W. Irving Pk. Rd., Apt. 4306, Chicago, IL 60613. Guadalajara; Mt. Sinai Fifth Pathway 1983. Board eligible. Group or partnership. Available July 1988.

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 AN ZELDA
 AS MEGA
 EY CRY
 SHEE

feel like a MILLION

ONCE-DAILY
INDERAL LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES 60, 80, 120, 160 mg

The one you know best
keeps looking better



60 mg 80 mg 120 mg 160 mg

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL® LA brand of propranolol hydrochloride (Long Acting Capsules)

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. **Hypertension:** INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. **CARDIAC FAILURE:** Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3 , and decreasing T_3 .

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. **GENERAL:** Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL (propranolol HCl) is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytol, phenobarbital, and rifampin accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and lidocaine have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Therophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dream appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Paryngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasisiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—Dosage must be individualized. Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—Dosage must be individualized. The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Reference:

1. Data on file, Ayerst Laboratories.

D7295/188

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**Autologous Blood
Donation; DRG
Payment System**

**Autologous Blood
Donation**

February 28, 1988

Dear Doctor Krosnick:

During the past few years, patients have become uneasy about receiving another person's blood. Transfusing predeposited autologous blood is a safe and viable solution to this problem. Risks of disease transmission are eliminated, side effects are uncommon, and patients are willing to predonate. However, a recent study demonstrated the widespread underutilization of predeposited autologous blood.¹

We surveyed the surgery departments of nine New Jersey teaching hospitals concerning autologous donation. Hospitals included in the survey were Morristown Memorial Medical Center, UMDNJ-Robert Wood Johnson Hospital, Saint Barnabas Medical Center, The Medical Center at Princeton, Hackensack

Medical Center, Muhlenberg Regional Medical Center, Newark Beth Israel Medical Center, St. Michael's Medical Center, and the VA Medical Center in East Orange. A total of 425 surgeons were surveyed and 263 responded (61.9 percent). Fifty-one percent stated that their patient's medical condition often precluded donation, 42 percent stated that predonation usually was not possible because of late surgical referrals, and 31 percent stated that they were unaware of the American Association of Blood Banks (AABB) guidelines for predonation.

The AABB guidelines for autologous donation are similar to those for homologous donation. Most centers require a hemoglobin of at least 11 g/dl before each donation and criterion exclude no one based on age alone. Patients with a wide variety of medical conditions including heart disease, pregnancy, and advanced age have safely predonated. The donation period roughly is from 42 to 3 days preoperatively and most centers collect blood at weekly intervals.^{1,2} Side effects associated with predonating are anemia and hypovolemia. These can be minimized by the daily oral administration of ferrous sulfate 325 mg given three times a day during the donation period and for at least three months postoperatively.²

The predepositing of autologous blood before elective surgery is endorsed by the AABB.³ Programs are available nationwide and fully 50 percent of the AABB institutional members offers a program. As patients become more reluctant to receive homologous blood, autologous donation will become a more important part of total patient care. It is essential that all physicians become familiar with this form of blood donation.

(signed) Joseph G. Barone, M.D.

1. Toy PT, et al.: Predeposited autologous blood for elective surgery—a national multicenter study. *N Engl J Med* 316:517, 1987.

2. Mann M, Sacks HJ, Goldfinger D: Safety of autologous blood donation prior to elective surgery for a

variety of potential "high-risk" patients. *Transfusion* 23:229, 1983.

3. Mintz PO: Autologous transfusion endorsed. *JAMA* 254:507, 1985.

DRG Payment System

January 19, 1988

Dear Doctor Krosnick:

Dr. Sapolsky's article, "An Evaluation of the New Jersey DRG Hospital Payment System," in the January 1988 issue of *NEW JERSEY MEDICINE* inspired a sense of déjà vu.

It simply is illusive to believe that industrial management techniques can be effectively applied to hospital cost accounting. Dr. Sapolsky is correct in concluding that hospitals "are more complex organizations than the DRG designers envisioned." In 1981, I co-authored an article in which we predicted that while the DRG program may be a salutary attempt to reduce the costs of the delivery of health care, strict compliance with the guidelines may indeed subject a hospital and a doctor to civil liability in a medical malpractice action (*J Med Soc NJ* 78:463, 1981).

In our article, I posited the omission of certain diagnostic tests on the grounds that they were unnecessary expense inconsistent with hospital policy of cost containment under the DRG program. In the article, which was designed to be a "think piece," I concluded that the hospital would be under liability for omission of the important diagnostic testing.

I bring this to your readership's attention now because I share the view in Dr. Sapolsky's article that while tighter DRG prices could save money, this might be perhaps at the cost of improvements in the quality of care.

I note from the editorial that the Medical Society of New Jersey is opposed to the DRG method of reimbursement. One of the reasons for this opposition, I submit, is the very real possibility of a diminution in sound patient care as a result of literal compliance.

Richard E. Brennan

THE PHILADELPHIA HEART INSTITUTE
of Presbyterian-University of Pennsylvania Medical Center

CARDIOLOGY UPDATE ...

designed for the Physician and provides an intensive survey of the
current status of Clinical Cardiology ...

WEDNESDAY
JUNE 1, 1988
3:00 to 5:00 PM

MEDICAL ECONOMICS—THE FINANCIAL PLIGHT
OF THE DOCTOR

MODERATOR: BERNARD L. SEGAL, M.D.

3:00-3:20	Influence of DRGs	<i>I. Donald Snook</i>
3:20-3:40	Influence of For-profit systems, HMOs, PPOs, etc.	<i>I. Donald Snook</i>
3:40-4:00	Solo versus group practice	<i>Robert Stein, Ph.D.</i>
4:00-4:20	Town and Gown conflict: Fact or fiction?	<i>Bernard L. Segal, M.D.</i>
4:20-5:00	Panel discussion	

- No Registration Fee
- No Advance Registration Required
- CME Credits*

* * Refreshments Served Following Each Session * *

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Presbyterian-University of Pennsylvania
Medical Center
39th and Market Streets
Philadelphia, Pennsylvania

Parking Available (at discount rate.)

*The University of Pennsylvania School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing education for physicians. The University of Pennsylvania School of Medicine designates this continuing medical activity for 2 credit hours per session in Category 1 of the Physician's Recognition Award of the American Medical Association.

CME CALENDAR

The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization for further information.

CARDIOLOGY

- June
- 1 **Anti-Arrhythmic Therapy/Clinical Arrhythmia**
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic (AMNJ)
 - 1 **Pacemaker Meeting**
8:30 A.M.-3 P.M.—Sheraton, Iselin (Overlook Hospital-Newark Beth Israel Medical Center)
 - 1 **Advanced Cardiac Life Support**
 - 8 6 P.M.—Freehold Area Hospital, Freehold (Freehold Area Hospital)
 - 16 **Ventricular Arrhythmias . . . When To Treat**
11 A.M.—St. Joseph's Hospital and Medical Center, Paterson (St. Joseph's Hospital and Medical Center)

DERMATOLOGY

- June
- 2 **Common Dermatoses**
2:30-3:30 P.M.—New Lisbon Developmental Center, New Lisbon (AMNJ)
- July
- 26 **Update on Superficial Fungal Infections**
3-4 P.M.—Maple Hall, Developmental Center at Ancora, Hammononton (AMNJ)

MEDICINE

- June
- 3 **Critical Decisions in Emergency Medicine**

- 8 A.M.-4 P.M.—Bally's Park Place Hotel and Casino, Atlantic City (American College of Emergency Medicine)
- 6 **Rheumatology Staff Conference**
5:30-7 P.M.—Robert Wood Johnson Medical School, MEB-393, New Brunswick (UMDNJ)
- 7 **Hirsutism**
7-8 P.M.—West Hudson Hospital, Kearny (West Hudson Hospital)
- 8 **New Treatments in Cerebrovascular Diseases**
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic (AMNJ)
- 8 **Medical Grand Rounds**
- 15 10 A.M.—St. Mary Hospital, Hoboken
- 22 (St. Mary Hospital)
- 8 **Joint Meeting: NJ Society for Gastrointestinal Endoscopy and NJ Gastroenterological Society**
3 P.M.—The Manor, West Orange (NJ Society of Gastrointestinal Endoscopy and NJ Gastroenterological Society)
- 14 **Myasthenia Gravis**
12 noon-1 P.M.—Hospital Center at Orange (AMNJ)
- 15 **Proper Use of Endoscopy**
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic (AMNJ)
- 16 **Entrepreneurial Medicine: Does It Challenge Traditional Medicine?**
5-6:30 P.M.—Fuld Auditorium, Somerset Medical Center, Somerville (Somerset Medical Center)
- 17 **Infectious Diseases—AIDS, Hepatitis, New Cephalosporins**
10:30-11:30 A.M.—Woodbridge Developmental Center (AMNJ)
- 18 **Cavity Lung Lesions**
7-8 P.M.—West Hudson Hospital, Kearny (West Hudson Hospital)
- 19 **Management of Bladder Dysfunction**
12 noon-1 P.M.—Community Memorial Hospital, Toms River (Community Memorial Hospital)
- 21 **Regional Nephrology Conference Series**
4-5 P.M.—Robert Wood Johnson Medical School, MEB, New Brunswick (UMDNJ)
- 30 **Diabetes of the Foot**
Satellite Teleconference, AMNJ, to New Jersey hospitals (AMNJ)

NEUROLOGY

- June
- 8 **New Treatments in Cerebrovascular Disease**
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic (AMNJ)

- 14 **Myasthenia Gravis**
12 noon-1 P.M.—Hospital Center at Orange (AMNJ)
- 30 **New Treatments in Cerebrovascular Disease**
2-3 P.M.—John E. Runnells Hospital of Union County, Berkeley Heights (AMNJ)

OBSTETRICS/GYNECOLOGY

- June
- 10- **Annual Meeting, NJ Obstetrical and Gynecology Society**
 - 11 The Hyatt Regency, Inner Harbor, Baltimore (NJ Obstetrical and Gynecology Society)
 - 23 **Perinatal Conference**
7-9 P.M.—Newcomb Medical Center, Vineland (Newcomb Medical Center)

ONCOLOGY

- June
- 2 **Cancer Research Colloquium**
 - 9 12 noon-1:15 P.M.—New Jersey Medical School, MSB, G-506B, Newark (UMDNJ)
 - 6 **Hematology/Oncology Conference**
 - 20 12 noon-1 P.M.—Robert Wood Johnson Medical School, MEB-108A, New Brunswick (UMDNJ)
 - 9 **Carcinoma of the Breast**
9-11 A.M.—Irvington General Hospital, Irvington (Irvington General Hospital)
 - 13 **Colon-Rectal Cancer**
7-8 P.M.—Wallkill Valley General Hospital, Sussex (AMNJ)
 - 23 **Tumor Board Conference**
12 noon—Newcomb Medical Center, Vineland (Newcomb Medical Center)

ORTHOPAEDICS

- June
- 6 **Orthopaedic Grand Rounds**
 - 13 7:30-9 P.M.—Robert Wood Johnson Medical School, New Brunswick (UMDNJ)
 - 20 **Clinical Examination of the Back, Knee, and the Hip**
8-9 A.M.—West Hudson Hospital, Kearny (West Hudson Hospital)

PATHOLOGY

- June
- 7 **Renal Pathology Conference**
12 noon-1 P.M.—Robert Wood Johnson Medical School, New Brunswick (UMDNJ)
 - 16 **Hematopathology Conference**
4-5 P.M.—Robert Wood Johnson Medical School, New Brunswick (Muhlenberg Medical Center)

PEDIATRICS

- June
- 3 **Advances in Pediatrics**
 - 10 9:30-10:30 A.M.—New Jersey

ACUPUNCTURE & ELECTRO-THERAPEUTICS IN CLINICAL PRACTICE

NY State Boards of Medicine & Dentistry 25-hour accredited seminar & workshop on the latest theories & techniques of manual and electro-acupuncture, TENS & simple non-invasive diagnostic methods (including cardio-vascular & neuromuscular systems & "BI-Digital O-Ring Test"), applicable toward the 300-hour requirement for MD & DDS acupuncture certification, given for licensed clinicians (with/out prior training) the weekends of **May 13-15, June 17-19 and Dec. 9-11, 1988** at the Milford Plaza Hotel, 45th St. and 8th Avenue, Manhattan. The *4th International Symposium on Acupuncture & Electro-Therapeutics*, with many world leading scientists & clinicians will be held at the Columbia U Sch. of Int. Affairs, NYC, **Oct. 13-16, 1988**. Co-sponsored by the Int. College of Acupuncture & Electro-Therapeutics; Its official journal, *Acupuncture & Electro-Therapeutics, Res., Int. J.* (published by Pergamon Press, Indexed in 15 major indexing periodicals: Index Medicus, etc.); Heart Disease Research Foundation; Neuroscience Dept. & NY Pain Ctr., Long Island College Hospital; (SUNY-Brooklyn Health Science Ctr.); Nordic Medical Acupuncture Society; & Schmerz-Therapeutische-Kolloquium (W. Germany); etc. Also eligible for AMA/CME credit, category 1. For info on meetings or submission of papers, contact Y. Omura, MD, ScD, 800 Riverside Drive (8-I), NYC 10032. Tel: (212) 781-6262 or (212) 928-0658, or P. Shinnick, PhD, (212) 941-0870 or Mr. Spence (212) 866-8499.

Approved Acupuncture Program by NYSBM&D.

June 6-10, 1988 UPDATE YOUR MEDICINE 1988

Association of Practicing Physicians of The New York Hospital and Cornell University Medical College. 33 hours Category 1 credit, (39 if optional workshops taken). A one week review of all subspecialties of internal medicine. 9 major review symposia, 4 lectures, 10 workshops, 2 Meet the Professor luncheons, optional practice workshops in breast/pelvic and male genitoretal examinations. Held at The New York Hospital-Cornell, 1300 York Avenue at 69th Street, New York. Information: Office of CME, 212-472-6119. Dr. Lila A. Wallis is Course Director.



Jersey Shore Medical Center

ENDOCRINE SEASHORE SYMPOSIUM

BREAKERS HOTEL
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THURSDAY, JUNE 2, 1988

A seminar for physicians emphasizing current diagnostic and treatment methods in Endocrinology. ANDROGEN EXCESS, ERECTILE DYSFUNCTION and DELIVERING ESTROGENS will be among the featured topics.

Contact the Department of Medicine, Jersey Shore Medical Center, Neptune, New Jersey 07753 for brochure. Telephone 776-4302.
COURSE FEE: \$35.00

(The Spring Lake Historical Society's Tour of Homes is scheduled on the same date.)

CHRONIC KILLERS: CARDIOVASCULAR DISEASE, HYPERTENSION & DIABETES

*An All-Day Symposium Cosponsored by the
Medical Society of New Jersey*

Wednesday, May 25, 1988 8 A.M.-3 P.M.
Quality Inn, Route 1 South, North Brunswick

Morning Speakers

Sylvia Herz, PhD
Molly Joel Coye, MD, MPH
William Tansey III, MD
Arthur Krosnick, MD
Pat Barta, RN, MPH
Marvin Rubin, DPM
Arthur Helfand, DPM
John Slade, MD
Roberta Feehan, RN, MA
Georgette Korch, MSN, RD, CPM
Michael P. Andronico, PhD

Afternoon Speakers

Stephen Fischl, MD	Lora Resignato, RN, BSNC
Elizabeth Congdon, RN, MA	Barbara Sosiak, RN, MSN
Betram Nussbaum, EdD	Leslee Oliu, RD, MPH
Lillian Kriegle, RN, MA	Judith Fancolini, RD

Program Information:

New Jersey Public Health Association
201/422-0200
201/297-8000

Continuing Medical Education Credits Have Been Approved

Registration Fee and Luncheon:
Deadline: May 15, 1988

\$20 NJPHA Members
\$30 Nonmembers

\$15 Seniors—Retired
\$ 5 Students (no lunch)

- 17 Medical School, MSB, B-610,
24 Newark
(UMDNJ)
- 7 **Case Conferences**
14 8-9 A.M.—Robert Wood Johnson
21 Medical School, MEB-108A,
28 New Brunswick
(UMDNJ)
- 9 **Pediatric Grand Rounds**
16 8:30-9:30 A.M.—Robert Wood
23 Johnson Medical School, MEB-102,
30 New Brunswick
(UMDNJ)
- 10 **Growing Up in the 1990s**
8 A.M.-12 noon—Overlook Hospital,
Summit
(Overlook Hospital)
- 14 **New Concepts in the Treatment of
Seizures and Epilepsy**
9:30-10:30 A.M.—Newark Beth Israel
Medical Center
(Newark Beth Israel Medical
Center)

PSYCHIATRY

June

- 2 **Case Seminars**
16 8-10 P.M.—312 Harding Drive,
South Orange
(Advanced Psychiatric Study
Group)
- 2 **Cold Cruelty and Loving
Humanity of Medicine**
12 noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)
- 3 **Psychiatric Lecture Series**
10 1:30-2:30 P.M.—Trenton Psychiatric
17 Hospital
(Trenton Psychiatric Hospital)

- 6 **Psychiatric Complications of
Multiple Sclerosis**
8:15-10:15 P.M.—325 Park Avenue,
Montclair
(Essex Psychiatric Seminars)
- 9 **Stress Management and Creative
Juggling for Clinicians**
12 noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)
- 16 **Scientific Meeting**
Saint Barnabas Medical Center,
Livingston
(NJ Psychoanalytic Society)
- 16 **This Is Me—Art Therapy with
Anorexics**
12 noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)
- 22 **Parenting/Children of Divorce**
9 A.M.-5 P.M.—Carrier Foundation,
Belle Mead
(Carrier Foundation)
- 23 **Medical and Psychiatric Aspects
of Drug and Alcohol Abuse**
3-4 P.M.—Ancora Psychiatric
Hospital, Hammonton
(AMNJ)
- 30 **Caring for the Caretakers:
Treating Impaired Professionals**
12 noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)
- July
- 7 **Treating Panic Disorder and
Agoraphobia**
12 noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)
- 14 **Assaults on Staff by Psychiatric**

Patients

12 noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)

21 Geriatric Patients

12 noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)

SURGERY AND

SURGICAL SPECIALTIES

June

- 4 **Surgical Treatment of
Cardiothoracic Diseases**
10-11:30 A.M.—New Jersey Medical
School, MSB, G-506, Newark
(UMDNJ)
- 6 **Morbidity and Mortality**
13 **Conference**
20 8:30-10 A.M.—New Jersey Medical
27 School, MSB, B-610, Newark
(UMDNJ)
- 15 **Surgical Conference**
11 A.M.—St. Mary Hospital, Hoboken
(St. Mary Hospital)

UROLOGY

June

- 1 **Urology Grand Rounds**
Robert Wood Johnson Medical
School, MEB-108B, New Brunswick
(UMDNJ)
- 22 **Clinical Cases Presentation**
6:30-7 P.M.—Robert Wood Johnson
Medical School, New Brunswick
(UMDNJ)

July

- 22 **Clinical Cases Presentation**
6:30-7 P.M.—Robert Wood Johnson
Medical School, New Brunswick
(UMDNJ)

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PHYSICIANS IN INTERNAL MEDICINE

VOL 5 NO 1 • JANUARY 1988

- ▲ Effect of Medical versus Surgical Therapy for Coronary Disease / PETER PEDUZZI, PhD, et al.
- ◆ Electrophysiological Testing and Nonsustained Ventricular Tachycardia / PETER R. KOWEY, MD, et al.
- ▲ Residual Coronary Artery Stenosis after Thrombolytic Therapy / LOWELL F. SATLER, MD, et al.
- Assessment of Aortic Regurgitation by Doppler Ultrasound / PAUL A. GRAYBURN, MD, et al.
- ▲ Embolic Risk Due to Left Ventricular Thrombi / JOHN R. STRATTON, MD
- Hemodynamic Effects of Diltiazem in Chronic Heart Failure / DANIEL L. KULICK, MD, et al.
- ◆ Cardiovascular Reserve in Idiopathic Dilated Cardiomyopathy / RICKY D. LATHAM, MD, et al.
- ▲ Overview • Coronary Angioplasty: Evolving Applications / GEORGE W. VETROVEC, MD

*Journals reviewed include: *Circulation*, *American Heart Journal*, *Journal of the American College of Cardiology*, *British Heart Journal*, *Chest*, *The American Journal of Cardiology*, *The New England Journal of Medicine*, *Annals of Internal Medicine*, *American Journal of Medicine*, and *The Journal of the American Medical Association*.

BOOK REVIEWS

Cardiology: A Clinical Approach; Clinical Endocrinology; Drug Treatment of the Rheumatic Diseases; Clinical Rheumatology Illustrated; 1987 Year Book of Hand Surgery; 1987 Year Book of Neurology and Neurosurgery; Walter B. Cannon. The Life and Times of a Young Scientist

Cardiology: A Clinical Approach. Second Edition

Ron J. Vanden Belt, M.D., James A. Ronan, Jr., M.D. Chicago, IL, Year Book Medical Publishers, Inc., 1987. Pp. 450.

The text provides a concise presentation of the pathology and physiological basis of clinical cardiology. This second edition has been updated to include new concepts regarding the understanding of normal heart function, physiology, pathology, and laboratory testing. It is a useful reference and is aimed primarily for medical students, residents, and others involved in the treatment of cardiac disorders. As a study manual, the authors have suggested that it may be comfortably read in portions over a four- to six-week period.

The contents are sectioned in a typical and orderly fashion and all relate to the field of cardiac diseases: history, physical examinations, laboratory tests, EKG findings, x-ray findings, and differential diagnoses. There are the sections on various cardiopathologies with discussions and descriptions of congenital heart, valvular and coronary diseases, hypertension, pulmonary function pathologies, and, finally, discussions and descriptions of the latest methods of cardiovascular surgical applications.

Each chapter is well illustrated and ends with a timely list of references. The manual is soft covered and has its merits as an easily carried and read study. It fills a gap: more detailed and larger than the jacket-pocket manual usually carried by the house staff physicians, but smaller and less detailed than the heavier hard-covered tomes. This text also would make a good study review for those preparing for their state or national boards in the field of cardiology.

Harry M. Poppick, M.D.

Clinical Endocrinology: An Illustrated Text

G. Michael Besser, M.D., and Andrew G. Cudworth, M.D., (eds). Philadelphia, PA, J.B. Lippincott Company, 1987. Pp. 275. (\$90)

This book covers most of the expected endocrine subjects except diabetes mellitus, but also includes chapters on hyperprolactinemia, endocrine hypertension, normal and abnormal sexual development and puberty, growth disorders, hypoglycemia and insulinomas, ectopic hormonal syndromes, radiology of endocrine disease, and neuroradiology of the pituitary and hypothalamus. The vast amount of knowledge utilized by the endocrinologist is rapidly and continuously increasing.

This text brings together endocrine physiology, histology, and diagnosis and therapy by employing numerous illustrations, photographs, tables, charts, and graphs. Many of these are in delightful color and are well organized as well as strategically placed within the text. This makes for clear understanding and learning, with retention of the subject presentation. Many radiographs including CAT scans (but no magnetic resonance images), with adjacent line diagrams, make for ease in reading and interpretation.

Most of the contributing authors are from the United Kingdom and, hence, we find more nmol/l and some less recognized medications. Welcome is the frequent comparison of the normal with the abnormal and the discussions combining the theoretical with the practical.

The text contains a great deal of endocrine information clearly brought together for ease of understanding, learning, and retention;

this book is recommended both for the novice and the clinician.

Mark M. Singer, M.D.

Drug Treatment of the Rheumatic Diseases, Third Edition

F. Dudley Hart (ed). Baltimore, MD, Williams & Wilkins, 1987. Pp. 229. (\$48)

Clinical Rheumatology Illustrated

F. Dudley Hart (ed). Baltimore, MD, Williams & Wilkins, 1987. Pp. 409. (\$80)

The first of these books is a well-written treatise on the pharmacologic aspects of the treatment of rheumatic diseases. It has two sections: the first section describes the pharmacological properties and side effects of all drugs used currently in rheumatology, and the second part discusses the practical treatment of some of the more common rheumatic diseases. However, I cannot recommend it to our readership in New Jersey since many of the drugs discussed are not available in the United States. This would be particularly confusing to nonrheumatologists who have enough difficulty attempting to recall all of the present anti-rheumatic drugs that are used.

In the second book, the author states one picture is worth a thousand words and he hopes that the many illustrations in this publication will be helpful. The problem with the book is that it is not a textbook nor an atlas: The color photographs are excellent but they are too few and far between. The black-and-white photographs are not all that helpful. The diagrams are good but, once again, they are too few. The radiographs are just fair with poor captions and no arrows to point out the pathology they describe.

As usual in a multiauthored text, I did find a couple of chapters written with clarity; some chapters were very educational, including one on the arthritic foot and one on the painful shoulder. I found the text incomplete with occasional glaring errors as in the chapter on systemic lupus erythematosus where it is stated that azathioprine (Imuran®) is relatively safe in pregnancy. Overall, I do not recommend it for a physician's library or even as a reference text. The *Atlas of Clinical Rheuma-*

tology would make a much better reference book, and lives up to the Chinese proverb, "A picture is worth a thousand words."

Sheldon D. Solomon, M.D.

1987 Year Book of Hand Surgery

James H. Dobyns, M.D., (ed). Chicago, IL, Year Book Medical Publishers, Inc, 1987. Pp. 330.

Doctors Dobyns, Chase, and Amadio again have done a wonderful job in editing the 1987 Year Book of Hand Surgery.

The book is very well organized; it is divided into 18 different chapters focusing on diagnosis and evaluation; different types of trauma and reconstruction; compression neuropathies; pain and vascular dysfunction syndromes; infection; occupational and avocational stress; arthritis; Kienböck's disease; tumors; congenital and pediatric problems; microsurgery; basic sciences; and research in hand surgery.

Each chapter has pertinent articles gleaned from 41 different journals. Each article has been summarized succinctly with a following critique pointing out the crux of the article and its weaknesses along with possible future ramifications in the field of hand surgery.

The book provides an excellent review of the recent literature in hand surgery for those who are hand surgeons and for those who maintain an interest in hand problems.

Harlan E. Hiramoto, M.D.

1987 Year Book of Neurology and Neurosurgery

Russel N. DeJohn, M.D., Robert D. Currier, M.D., Robert M. Crowell, M.D., (eds). Chicago, IL, Year Book Medical Publishers, Inc., 1987. Pp. 495.

This book, 34th in the annual

series from Year Book, has been "published without interruption since 1902," according to the title page. Until 1970, the text covered neurology, neurosurgery, and psychiatry. The knowledge explosion responsible for splitting the book into two separate volumes that year may well necessitate a further separation by the turn of the century if not sooner.

Half of the present edition is devoted to each of the two specialties. Each section is subdivided into the major topics within that specialty. For each topic, the editors have selected from the general literature several articles which they present in abstract form and follow with a commentary.

The commentaries generally are thoughtful and occasionally witty. Dr. Crowell, the neurosurgeon, tends to comment at greater length and more analytically. Each editor reveals his biases in his selections and comments, and no reviewers' opinions will coincide. Both the choices and the critiques, however, are fair.

The resulting overview of the literature is appropriately geared to clinical application. The researcher will be better served by the original articles in his own corner.

Clement H. Kreider, Jr., M.D.

Walter B. Cannon. The Life and Times of a Young Scientist

Saul Benison, A. Clifford Barger, Elin L. Wolfe. Cambridge, MA, Belknap Press of Harvard University Press, 1987. Pp. 520. Illustrated. (\$30)

A medical historian, a physiologist, and an archivist combined their considerable talents to produce a remarkable book that deftly integrates the biography of an eminent American physiologist with a detailed history of medical educa-

tion at Harvard University. Social historians undoubtedly will focus on the "times." I truly was captivated by the "life."

What a wonderful coincidence that Cannon was born in Prairie du Chien, Wisconsin, where 40 years earlier William Beaumont made some of his classic observations on gastric function, because Cannon also distinguished himself through his work on the physiology of the digestive tract. Cannon's ingenious use of x-rays and bismuth to investigate a wide range of subjects, from the mechanics of swallowing to the effects of emotion on gastrointestinal motility, were summarized in *The Mechanical Factors of Digestion* (1911), a book that still is an intellectual treat.

Always concerned about the clinical applications of his work, Cannon collaborated with John B. Blake in a series of experiments that showed that pyloroplasty was preferable to gastroenterostomy in treating non-malignant pyloric stenosis. Many notable surgeons, such as William Mayo, acclaimed the implications that this research had for their profession.

Influenced by one of his Ph.D. students, Cannon shifted his interests to endocrinology; this led subsequently to his classic studies on the role of emotion, e.g. fear and rage, in the secretion of adrenaline. He hypothesized that in emergencies, the adrenal medulla functioned to prepare the body for fight or flight. Although other prominent men had dissenting views, the issue was eventually resolved in Cannon's favor.

The book ends with Walter B. Cannon, at age 45, sailing for France with the Harvard Unit at the beginning of America's involvement in the Great War. But, readers will want more! Hopefully another volume will be published in the not too distant future.

Vincent J. Cirillo

***Drs. Abbott; Aria; Barrows;
Cobots; Cunningham; Forer;
Freeman; Gibbins; Glover;
Greene; Levinson; Praport;
Viteri; Yachnin***

Dr. Frank V. Abbott

Family practitioner and internal medicine specialist Frank Victor Abbott, M.D., died on December 19, 1987, at the age of 76. Born in South Orange, Dr. Abbott received his medical degree from the University of Bologna, Italy, in 1942. He served on the staff of Morristown Memorial Hospital, and was a member of our Morris County component and of the American Medical Association.

Dr. Michael H. Aria

Jersey City specialist in general surgery, Michael H. Aria, M.D., died on February 7, 1988, at the age of 89. A native of Messina, Italy, Dr. Aria received his medical degree from Eclectic Medical College, Cincinnati, Ohio, in 1926. He became affiliated with Palisades General Hospital, North Bergen; Riverside General Hospital, Secaucus; and Greenville Hospital, and Jersey City Medical Center, both in Jersey City. Dr. Aria was a member of our Hudson County component and of the American Medical Association. In 1976, he received MSNJ's Golden Merit Award for 50 years of medical practice.

Dr. Victor I. Barrows

Family physician Victor Ira Barrows, M.D., died on November 16,

1987, in Holiday, Florida, where he had been retired. A 1921 graduate of Jefferson Medical College of Philadelphia, Pennsylvania, Dr. Barrows maintained a North Wildwood practice and served on the staff of Burdette Tomlin Memorial Hospital in Cape May Courthouse. He was a member of our Cape May County component and of the American Medical Association. For 50 years of medical practice, Dr. Barrows received MSNJ's Golden Merit Award in 1971.

Dr. Joseph C. Cobots

Retired ophthalmologist Joseph Charles Cobots, M.D., died in May 1987, at the age of 81. Born in Italy, Dr. Cobots attended Jefferson Medical College of Philadelphia, Pennsylvania, where he received his medical degree in 1930. He became affiliated with Chester Hospital, Pennsylvania, as chief of ophthalmology; Wills Eye Hospital, Philadelphia; Crozer Hospital, Upland, Pennsylvania; and Sacred Heart Hospital, Chester, Pennsylvania. A Diplomate in ophthalmology, Dr. Cobots was a member of our Cape May County component and of the American Medical Association. In 1980, Dr. Cobots received MSNJ's Golden Merit Award.

Dr. Joel B. Cunningham

A general practitioner in Camden and Pennsauken for 45 years, Joel Bates Cunningham, M.D., 78, died on February 7, 1988, after 4 years of retirement. A native of Konawa, Oklahoma, Dr. Cunningham received his medical degree from the University of Arkansas School of Medicine, Little Rock, in 1936. He maintained a Camden practice from 1939 until 1969, when he moved to Pennsauken. During World War II, he served with the United States Army medical corps for 3 years, attaining the rank of major. Dr. Cunningham was a member of our Camden County component, and of the American Medical Association. In recognition of 50 years as a physician, Dr. Cunningham received MSNJ's Golden Merit Award in 1986.

Dr. Robert Forer

Trenton pediatrician Robert Forer, M.D., 84, died on February 29, 1988. A native of Poland, Dr. Forer

received his medical degree from New York University School of Medicine, New York, in 1928. A lifelong Trenton area resident, Dr. Forer maintained a Bellevue Avenue pediatric practice for 55 years, retiring only recently. Affiliated with Mercer Medical Center as its chief of pediatrics, and with Children's Hospital, Philadelphia, Dr. Forer was consulting pediatrician for the Trenton Head Start and Follow-Through programs; pediatrician for the Henry J. Austin Health Center, Trenton, from 1969 to 1983; and founder of the Medical Journal Club of Trenton. He was a United States Army medical corps veteran of World War II, having attained the rank of major. In 1978, he received the Medical Society of New Jersey's Golden Merit Award recognizing his 50 years as a physician. Dr. Forer was a member of our Mercer County component and of the AMA.

Dr. Joseph Freeman

Joseph Freeman, M.D., a family physician in Bayonne, died on January 25, 1988, at the age of 78. A native of Poland, Dr. Freeman was graduated from New York University School of Medicine, New York, where he received his medical degree in 1935. He became affiliated with Bayonne Hospital, and also maintained a private practice in Bayonne. He was a member of our Hudson County component and of the American Medical Association. For his 50 years as a physician, Dr. Freeman received MSNJ's Golden Merit Award in 1983.

Dr. A. Leslie Gibbins

General practitioner Albert Leslie Gibbins, M.D., died on December 27, 1987, at the age of 79. Born in Newark, Dr. Gibbins received his medical degree from Bellevue Hospital Medical College, New York, in 1933. He served on the staffs of Clara Maass Medical Center, Belleville; and Presbyterian Hospital, Newark. A Fellow of the American College of Surgeons, Dr. Gibbins was a member of our Ocean County component and of the American Medical Association. During World War II, he attained the rank of commander in the United States Navy. Dr. Gibbins received MSNJ's Golden Merit Award in 1983, for his 50 years of medical practice.

Dr. Lawrence L. Glover

Retired for 7 years in Toledo, Ohio, former Haddonfield family physician Lawrence Litchfield Glover, 70, died on February 19, 1988, at the age of 93. Born in Haddonfield, Dr. Glover received his medical degree from the University of Pennsylvania School of Medicine, Philadelphia, in 1920. He established a private practice in his hometown, maintaining this practice over 50 years, until his retirement. Dr. Glover was a member of our Camden County component and of the American Medical Association. He was a United States Army veteran of World War I. In 1970, Dr. Glover received MSNJ's Golden Merit Award.

Dr. Frank M. Greene, Jr.

Obstetrician-gynecologist Frank Matthew Greene, Jr., M.D., 47, died on February 9, 1988. Born in Passaic, Dr. Greene received his medical degree from Hahnemann Medical College and Hospital, Philadelphia, in 1966. For 15 years, he had a Carlstadt private practice, and became affiliated with Hackensack Medical Center. A Diplomate in obstetrics and gynecology, and a Fellow of the American College of Obstetricians and Gynecologists, Dr. Greene was a member of the American Fertility Society, of the New York Academy of Sciences, of our Bergen County Component, and of the American Medical Association. He was a veteran of the Vietnam War, serving as lieutenant and general surgeon in the United States Navy.

Dr. Reuben Levinson

General surgeon Reuben Levinson, M.D., died on February 22, 1988, at the age of 79. A native and life-long area resident of Perth Amboy, Dr. Levinson received his medical degree from the Faculty of Medicine, University of Edinburgh, Scotland, in 1936. He became affiliated with Raritan Bay Medical Center, Perth Amboy, and John F. Kennedy Medical Center, Edison. He maintained a private practice in Perth Amboy for many years. A Fellow of the International College of Surgeons, Dr. Levinson was a member of the Middlesex County component and of the American Medical Association. He was a veteran of World War II, having served as captain in the United States Army. Dr. Levinson was a 1986 recipient of MSNJ's Golden Merit Award.

Dr. Benny Praport

Gastroenterologist Benny Praport, of Elizabeth, died on December 16, 1987, at the age of 40. Born in Lodz, Poland, Dr. Praport received his medical degree from the University of Bologna, Italy. He became affiliated with Elizabeth General Medical Center, St. Elizabeth Hospital, and Alexian Brothers Hospital, all in Elizabeth. Dr. Praport was a member of the Academy of Medicine of New Jersey, of our Union County component, and of the AMA.

Dr. Luis E. Viteri

Retired Mt. Holly internist Luis E. Viteri, M.D., died on January 16,

1988, at the age of 84. Born in Ecuador, Dr. Viteri received his medical degree from the University of Pennsylvania School of Medicine, Philadelphia, in 1926. A Diplomate in internal medicine, Dr. Viteri was a Fellow of the American College of Physicians, and was a member of our Burlington County component and of the American Medical Association. In addition to maintaining a private practice, Dr. Viteri was affiliated with Memorial Hospital of Burlington County. He was a major in the United States Army during World War II. Dr. Viteri received MSNJ's Golden Merit Award in 1976.

Dr. Samuel C. Yachnin

Retired orthopedic surgeon Samuel C. Yachnin, M.D., 83, died on January 19, 1988, in Florida. A native of Russia, Dr. Yachnin received his medical degree from New York University School of Medicine, New York, in 1927. A Diplomate in orthopedic surgery, Dr. Yachnin was a Fellow of the American Academy of Orthopedic Surgeons and of the American College of Surgeons. He became affiliated with Beth Israel Hospital, Passaic, and the General Hospital Center at Passaic, where he was chief of orthopedics. Dr. Yachnin was consultant to orthopedic surgeons in the Virgin Islands, and to Patrice Air Force base in Florida. He was a member of our Passaic County component and of the AMA. He was a colonel in the United States Army. In 1977, he received the Golden Merit Award.

AUTHOR INFORMATION

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CONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable

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2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

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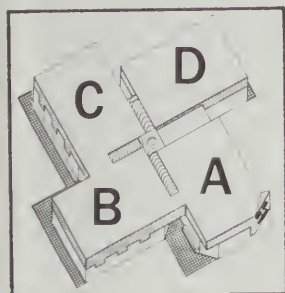


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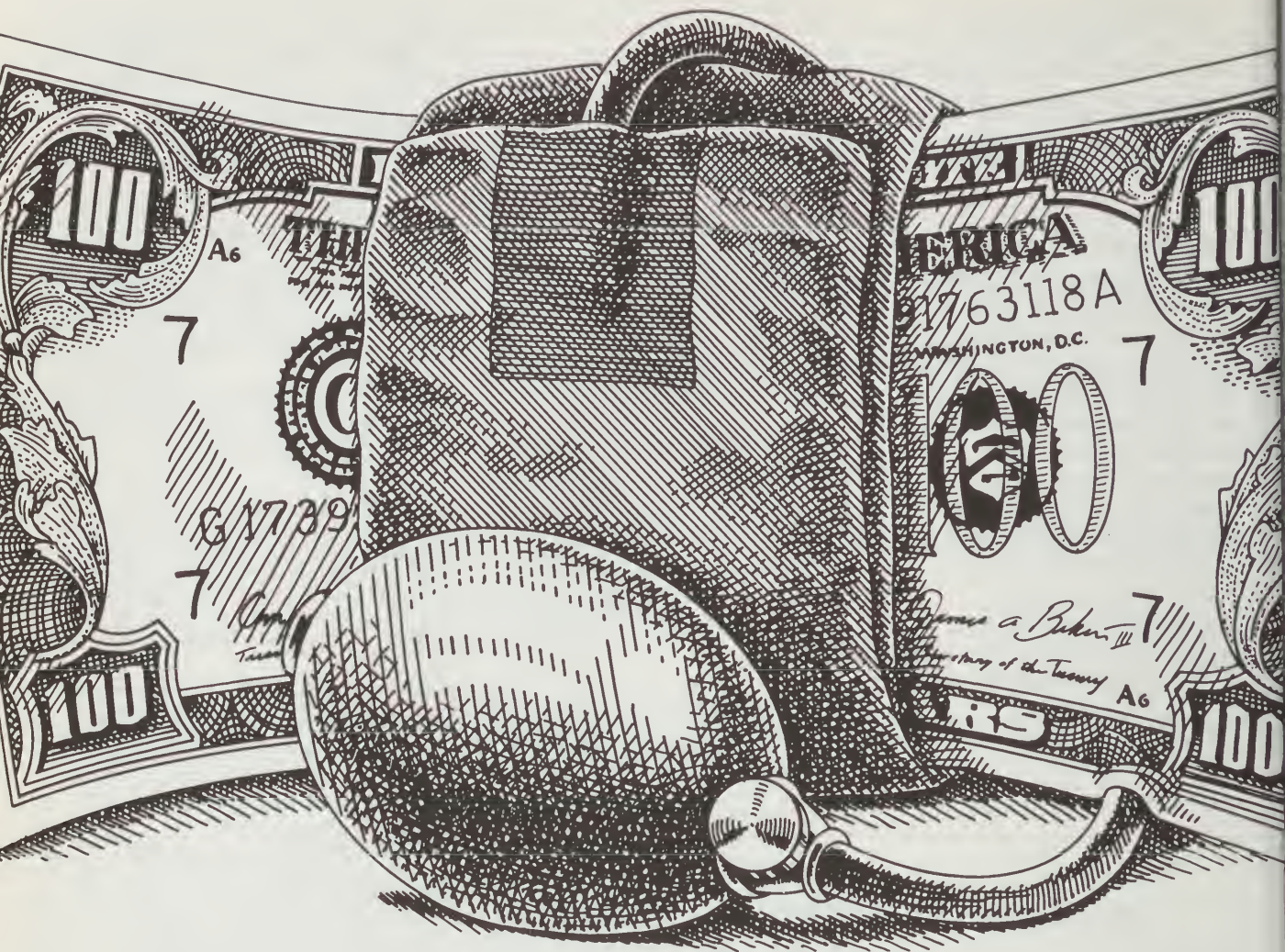
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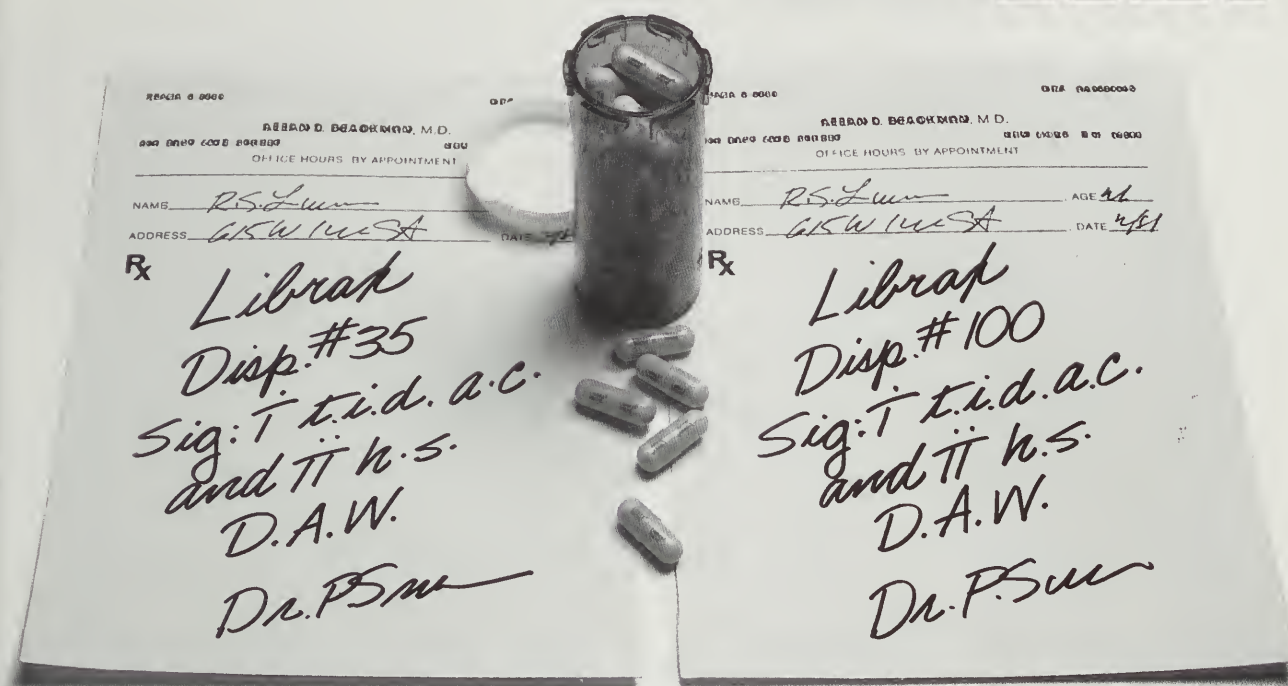
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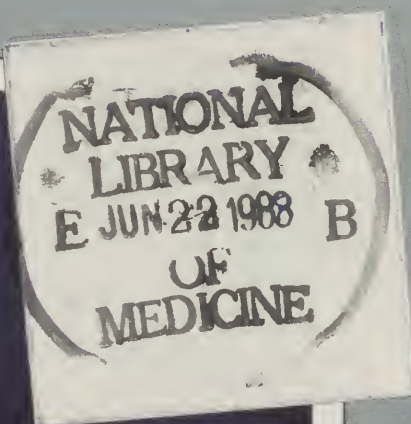
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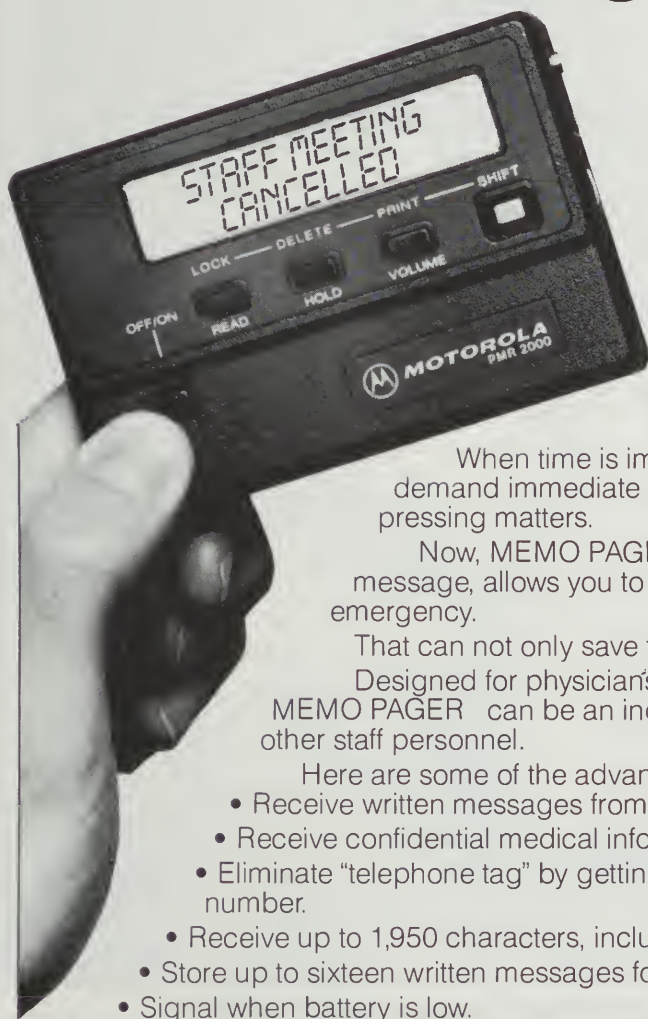
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JUNE 1988

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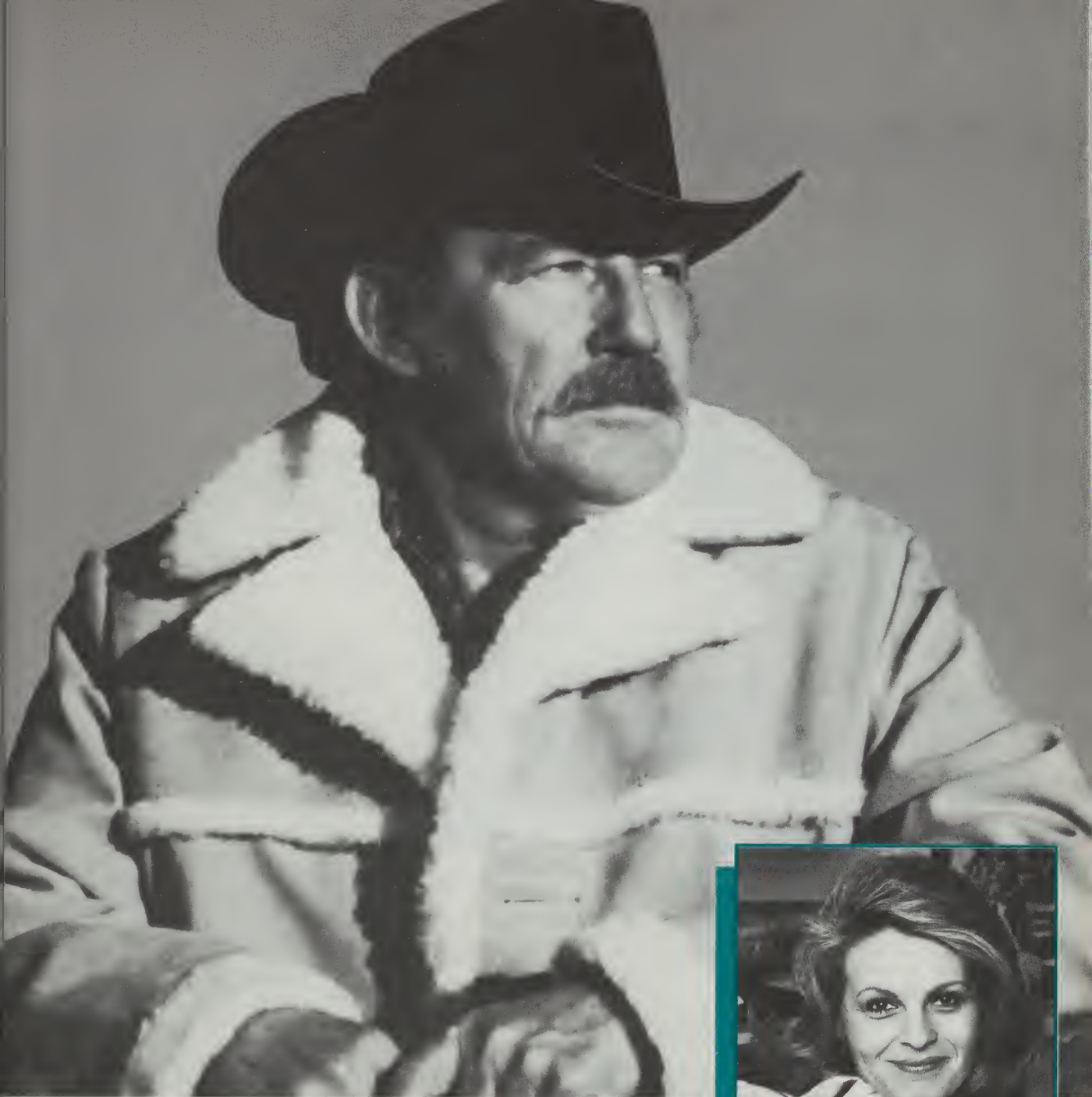
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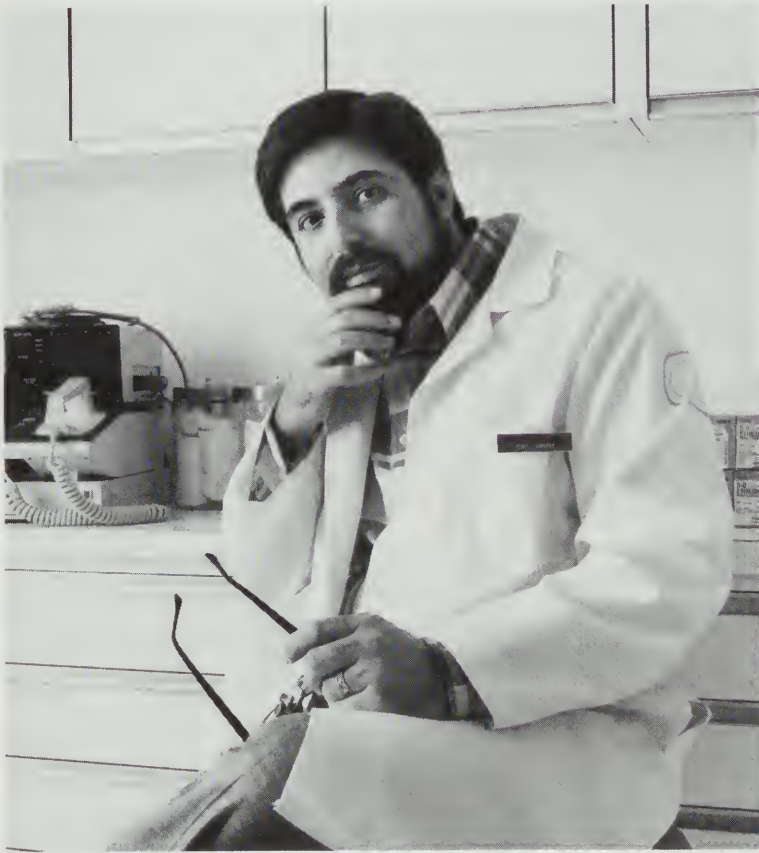
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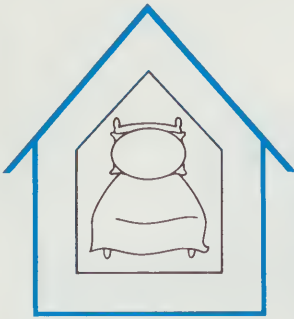


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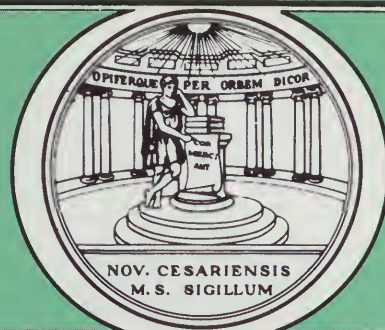
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MEMBERSHIP NEWSLETTER



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THE MEDICAL SOCIETY OF NEW JERSEY

VOLUME 55

AMERICAN MEDICAL ASSOCIATION

Price Controls

The AMA commissioned a panel of economic experts to determine whether or not the imposition of price controls was an appropriate method to be used in controlling the rise in cost of medical care. The panelists included: Elizabeth E. Bailey, William J. Baumol, James M. Buchanan, Carl F. Christ, H.E. Frech, III, Lawrence R. Klein, Marc L. Nerlove, Sam Peltzman, James B. Ramsey, Richard L. Schmalensee, Martin Shubik, and Sir Alan Walters. The following is a summary of their report:

During the last several decades, the costs of medical services have been rising at a rate persistently more rapid than that of the general price level. This constitutes a real and very urgent problem for the poor, in general, and for the elderly poor, in particular. But it is a problem which cannot be solved by legislation which seeks to declare its symptoms illegal. Recent proposals undertaking to impose ceilings on the fees that doctors would be permitted to charge their Medicare patients amount to the imposition of a system of price controls. As with most price control measures, these proposals are not only likely to fail to achieve their objective, but are apt to impose a costly burden upon the very persons whose interests they would attempt to protect.

In common with many other personal services, such as education, the performing arts, and a variety of services performed by state and local governments, the costs and prices of medical services have indeed risen at rates substantially higher than the economy's overall rate of inflation. During the 40-year period since 1947, according to U.S. government statistics, in constant dollars, the price of a visit to a doctor's office has risen some 150 percent, the cost of elementary education per pupil per day has risen about 300 percent, and the cost of a day of hospital care has increased approximately 1,750 percent.

No one is sure of the full explanation of these very substantial increases in the cost of medical services. But the rising physician-population ratio, the rising proportion of applicants accepted by medical schools, the increase in the number and membership of organizations such as HMOs (health maintenance organizations) and PPOs (preferred provider organizations) whose objective is to hold down medical care costs, and the fact that (in constant dollars) physician incomes have been virtually constant for more than a decade, all suggest that there has been no decline in

competitiveness in the health care area such as would account for the pattern of sharp increase in the relative prices of medical services. There is good reason to conclude, rather, that a substantial role was played by the fact that medical care is a personal service which is not amenable to the rates of productivity increase which, for example, have constrained the rates of price increases of manufactured products.

It is important to explore the sources of the price increases experienced by medical services because only after the causes are understood can a rational policy for the containment of the effects of those price increases be formulated. Moreover, to the extent that the price increases are to be attributed to real and largely unavoidable cost increases, rather than to the imperfect competitiveness of the medical care industry, the perils of the price control approach are necessarily exacerbated. If rising prices merely reflect real and unavoidable cost increases, a ceiling in prices will inevitably serve, in the long run, to curtail the supply of medical services in general; and a ceiling on fees for the treatment of the elderly is sure to reduce the quality and quantity of services supplied to this population group. Experience shows that, in the long run, it may even increase the prices this group is required to pay. In sum, such controls under these circumstances would constitute no benefit to the group of persons they are intended to protect.

We strongly urge that price controls for medical services not be adopted precipitously. We believe that careful consideration of the matter will make it clear that price control measures for medical services are to be avoided altogether, and that a serious social problem such as this one merits a more reasoned and more promising approach.

MEDICAL SOCIETY OF NEW JERSEY

Auxiliary Information

The Auxiliary supplies needed assistance to the Society in many areas. Lobbying assistance and medical student loan fundraising by Auxiliary members have been invaluable to our efforts.

The Board of Trustees encourages each of you to urge your spouse to become a member of the Auxiliary, and to participate in its physician-focused activities.

FINI

"When you get wrapped up in trivialities and lose sight of yourself, you're lost." Brendon Phibbs, M.D., author of *"The Other Side Of Time."*

PUBLIC AFFAIRS UPDATE

CLARK MARTIN*

**Medical Waste News;
Financial Disclosure
Advances; Monopoly
on Modalities**

GOOD NEWS ABOUT MEDICAL WASTE

A medical waste bill which would have created added expense and red tape has been amended so that it no longer would burden the private physician.

Sponsored by Assemblyman Anthony "Doc" Villane (R-Eatontown), A-2853 now would affect only facilities such as hospitals, ambulatory surgical centers, clinics, and nursing homes. Part of a package of bills intended to prevent ocean and beach pollution, the measure would create a new method of monitoring and disposing of medical waste.

In its original form, A-2853 was the joint product of the Department of Health and the Department of Environmental Protection (DEP). It required physicians and other practitioners to register with the DEP, separately package and identify their waste as either "general" or "special," and assure that it is hauled away by garbage specialists. If enacted, the bill would have been a nightmare. It contemplated a solid waste collection and manifesting system which today does not exist. And it required special handling for such benign items as rubber gloves, tongue depressors, bandages, and cotton swabs which in the household would be considered ordinary trash.

Assemblyman Villane strongly supported the Society's amendment. Working with health care providers and other affected professions (dentists, hospitals, nursing homes, funeral directors, and veterinarians) we proposed a number of alternatives to him and to the sponsor of a companion Senate bill, Frank Pallone (D-Long Branch).

With the amendments, the bill now requires affected facilities to arrange for the separate handling of "special" medical waste: infectious waste, body parts, needles, syringes, sharps, and pathology specimens.

The Health Department insists that private practitioners be brought back into the bill, and the DEP still wants special treatment for "general" medical waste. Thus, additional legislation may follow.

FINANCIAL DISCLOSURE ADVANCES

Financial disclosure—the Society's alternative to lobbying efforts aimed at prohibiting physicians from owning a variety of health care services—is well on its way to becoming law.

Sponsored by Senators Richard Codey (D-West Orange) and John Russo (D-Toms River), a disclosure bill has passed the Senate unanimously and has been sent to the Assembly Health Committee.

The bill, S-734-2091, affects practitioners regulated by the State Board of Medical Examiners (physicians, podiatrists, and chiropractors). It acknowledges their right to own or invest in health care services, and requires them to disclose that fact whenever they refer a patient to a facility in which they, or a member of their immediate family, have an interest.

Disclosure is required if the practitioner owns 5 percent or more of the service, or if the investment exceeds \$5,000. Ownership of a building in which space is leased to a health care service need not be disclosed.

The bill applies to such services as a pharmacy, nursing home, bioanalytical laboratory, home health care agency, radiological facility, and ophthalmic service.

At the Society's suggestion, a provision was deleted which would require a practitioner to give the patient the names, addresses, and telephone numbers of at least three alternative providers of a service. The bill requires the patient be given a disclosure form noting other services can be found in the classified section of the telephone directory.

An identical bill, A-2485, has been introduced in the lower house by Assemblyman Chuck Haytaian (R-Hackettstown). It, too, has been referred to the Assembly Health Committee.

MONOPOLY ON "MODALITIES"?

It's no secret that physical therapists are chafing under the Medical Examiners' rule which permits practitioners to direct an unlicensed employee to administer "physical modalities." Elimination of this rule was one of the goals of the PT prohibition bill (A-2647) which failed in the last legislative session and now has been superseded by the financial disclosure measure.

Thus, we're not surprised to discover a new bill which would prohibit a physician, podiatrist, or chiropractor from using any employee, other than a physical therapist, to administer physical modalities. The bill S-2509/A-3166 is sponsored by Senator John Lynch (D-New Brunswick), Assemblymen Anthony Impeveduto (D-Secaucus), and Joseph Doria (D-Bayonne).

Modalities mentioned in the bill include heat, diathermy, cold, ultrasound, ultraviolet rays, cold quartz rays, and electromagnetic rays.

While the bill would foster employment for physical therapists, we wonder whether it has anything to do with improved health care.

*Mr. Martin is MSNJ's legislative consultant.

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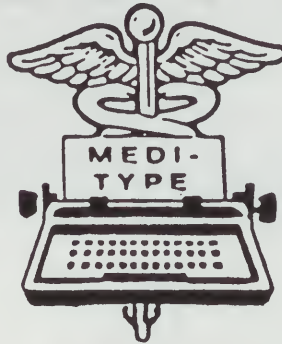
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State Affairs

Board of Registration's Decision To Revoke License for Negligence in Another State; Missouri Court Does Not Have Jurisdiction over Texas Hospital; New Pap Test Guidelines; Blood Donor Identities; Consulting Activities of Expert Witness

COURT UPHOLDS BOARD OF REGISTRATION'S DECISION TO REVOKE LICENSE FOR NEGLIGENCE IN ANOTHER STATE

Distracted by malpractice costs and lawsuits, physicians may not be aware that state boards of registration have adopted newly aggressive postures. Once sleepy entities that rarely disciplined physicians, today these boards have been given the mandate and the staff to find and discipline medicine's "bad apples."

As the number of license revocations and suspensions have risen, physicians who have been punished have appealed to the courts. These appellate decisions suggest that the boards have great power and wide latitude in which to exercise it, as the following case (Haran versus Board of Registration in Medicine, 398 Mass 571, 1986) illustrates.

In 1979, a disciplinary authority in New York determined that Patrick Haran was guilty of negligence and professional incompetence on at least 12 occasions and revoked his license. Dr. Haran also was licensed in Massachusetts. About a year later, the Massachusetts Board of Registration in Medicine adopted a rule permitting it to give collateral estoppel effect to a sister state's disciplinary actions if they were "for reasons substantially the same as those for which a physician might be disciplined in Massachusetts."

In 1981, based exclusively on the New York determination, the Massachusetts Board initiated action against Dr. Haran, and in 1984 it voted to suspend his license for two years. Noting however, that in the in-

terim Haran had regained his New York license, it stayed the suspension.

Dr. Haran appealed the decision to a single justice who vacated the suspension, ruling that it was inappropriate to apply the collateral estoppel rule retroactively. The Board appealed to the Supreme Judicial Court which reinstated the decision. The Supreme Judicial Court held that the rule had not been applied retroactively, noting that for a statute to be found to operate retroactively it must be shown that "substantive" as opposed to procedural rights were adversely affected.

Dr. Haran's arguments had systematically addressed this point, but the Supreme Judicial Court was unpersuaded. It rejected his view that the term "substantially" made the regulation so loosely drafted as to permit the board to discipline him for conduct prescribed elsewhere, but not in Massachusetts. It also rejected his argument that he should have a chance to disprove what was decided in New York.

Dr. Haran's most persuasive point was that if the Massachusetts Board was going to act solely on the basis of a sister state's disciplinary action, it must do so entirely. Since New York had returned his license, Massachusetts should not now suspend it. This, too, the higher court rejected, agreeing with the Board that the determination of rehabilitation was much less well suited to collateral estoppel than was a finding of negligence. It found the regulatory design to be neither unreasonable nor unfair. It wrote that the Board should enjoy wide latitude not only to decide factual questions on the basis of the members' expertise, but also to decide on that same basis whether the issue of rehabilitation is or is not a question for collateral estoppel.

There are few better examples of the vast powers of state boards than this case. (*Medical Liability Monitor*, Vol. 13, Number 2, February 29, 1988)

MISSOURI COURT DOES NOT HAVE JURISDICTION OVER TEXAS HOSPITAL

A Texas hospital that provided a donor heart for a transplant was not subject to jurisdiction in a wrongful death action in a Missouri court, a Missouri appellate court ruled. The hospital had provided a blood type A heart for a transplant into a patient in St. Louis. After removal of the patient's heart and shortly before completion of the operation, the operating physician was advised that the donor heart was in fact of blood type B. Having no other heart available, the physician completed the operation. After some time, the patient began rejecting the heart. Another transplant was performed, but that heart deteriorated and the patient subsequently died. The patient's widow filed a wrongful death action against the operating physician and the hospital that had provided the donor heart. The trial court denied the hospital's motion to dismiss for lack of jurisdiction. The hospital then sought an order from the appellate court to prevent further action of the trial court. Granting the hospital's request, the

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are Director of the Department and Director of Special Projects, respectively.

court said that the hospital did not have sufficient minimum contacts with the state of Missouri to satisfy due process requirements. The Texas hospital was not subject to the jurisdiction of the Missouri court. (Reprinted from *Citation* (Volume 56, No. 4, December 1, 1987), with permission, AMA, 535 N. Dearborn St., Chicago, IL 60610)

NEW PAP TEST GUIDELINES

Conservative time intervals when Papanicolaou (Pap) smears generally should be performed were recommended by four national medical organizations at a press conference held at the Press Club in Washington, D.C. The consensus guidelines were discussed by representatives of the American Cancer Society, AMA, American College of Obstetricians and Gynecologists, and The National Cancer Institute. Developed during the past year, the guidelines are intended to encourage professional consistency in time intervals for scheduling Pap smear screens. They also allow for flexibility based on professional judgment for patients whose histories indicate they may be at a higher risk of developing cervical cancer.

Harry Jonas, M.D., AMA's Director of Undergraduate Medical Education, explained the reasons why the four medical groups developed the guidelines. "For the past eight years," he said, "American women must have been confused with the conflicting advice they were getting from the major health and medical organizations about how often they should have Pap tests as protection against getting cervical cancer. Today we hope to put to rest some of that confusion." The guidelines, which were approved by the AMA's House of Delegates at the 1987 Interim Meeting call for three successive annual screens for sexually active women over age 18. If test results are negative, subsequent periodic screens should be performed at the discretion of physician and patient, but not less frequently than every three years, the organizations recommend. (*FedNet*, February 1, 1988)

DISCOVERY OF BLOOD DONOR IDENTITIES

Court-ordered discovery of the identities and addresses of blood donors did not violate the donors' liberty interests, a Texas appellate court ruled.

The father of a patient who contracted AIDS and died after receiving blood transfusions sued a hospital for wrongful death. He accused the hospital of failing to exercise the degree of care, skill, and treatment ordinarily expected and failure to provide a wholesome blood product.

The father served the hospital with a request for production of information relating to blood donors. The trial court overruled the discovery objection and ordered that the hospital disclose the identities and addresses of the donors. The court ordered the father not to directly or indirectly contact any donor or undertake further discovery as to such donors until permitted to do so by court order.

The hospital sought a writ of mandamus to compel the trial judge to rescind the order permitting discovery. The hospital contended that the order violated the blood donors' constitutional right to privacy and that the societal interest in maintaining a healthy and

effective blood donor program overrode any legitimate interest in disclosure of the blood donors' identities.

The appellate court found that the physician-patient privilege was not applicable, since nothing in the record indicated that the blood donors were seen by a physician or received medical care when they donated the blood. The court also held that the order was not an impermissible violation of the donors' rights to privacy. The court said that the father's interest in the identity of the donors was legitimate. Without such information, the court said, it was unlikely that he could prosecute the cause of action against the hospital. Further, the court said that the record did not support the hospital's contention that the donors had a need of anonymity that was greater than the father's need.

From the record, the court said that it appeared that the hospital had made no effort to determine whether any of its donors had been identified as having AIDS. The court said that a finding of injury to society's interest by the limited discovery was no less speculative than a determination that the order would benefit society by discouraging blood donations by AIDS victims. The hospital did not provide evidence to show that the information sought would be used improperly.

Since the trial court's order showed a proper concern with protection of the individual's right of privacy, the court denied the hospital's motion for a writ. (Reprinted from *THE CITATION*, January 15, 1988, Vol. 56, No. 7, with permission, AMA, 535 N. Dearborn St., Chicago, IL 60610)

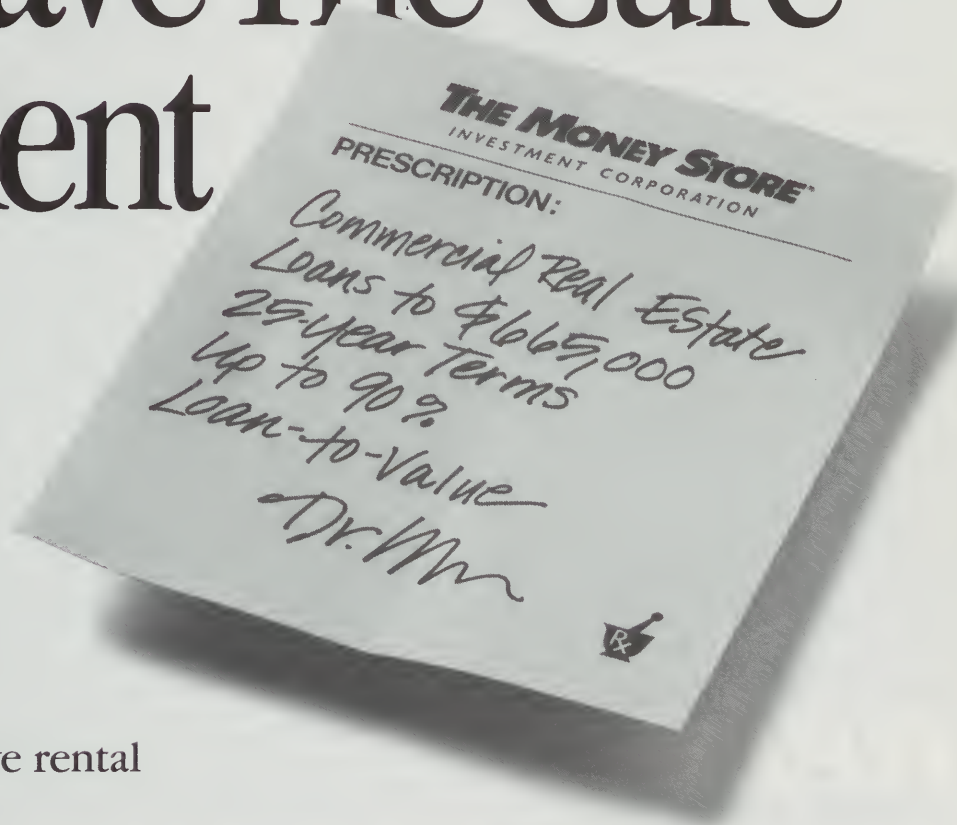
CONSULTING ACTIVITIES OF EXPERT WITNESS

The Illinois Supreme Court has unanimously held that a trial court has discretion to permit cross-examination of an expert witness in a medical liability action with respect to the number of cases in which he had testified and his annual income derived from expert counseling activities. The decision reversed the appellate court and marks a departure from an older line of Illinois cases which suggested that expert witnesses should not be questioned regarding such matters.

In the course of the trial, the expert physician testified on direct examination as to his education, his experience as a general practitioner, and other qualifications. He also stated that he was asked to review the case by the American Board of Medical Legal Consultants which he described as a group of consultants of which he was a "fellow," that attempt to determine whether "lack of standard of care, injuries, or malpractice has occurred in a variety of cases."

On cross-examination, the expert physician indicated that the Board was a profit-making organization, the purpose of which was to review cases involving suspected malpractice and to furnish expert testimony. He stated that more than 80 percent of his time was devoted to work for the Board and that since 1983, he had reviewed more than 700 cases, given depositions in approximately 60 of these cases, and testified in about 30 trials. These trials involved a diversity of medical treatments, ranging from alleged inadequate neurological examination to the development of bone infection. The expert physician also testified that the majority of his work was for plaintiffs. (*Professional Liability Update*, March 1988.)

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Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlordiazepoxide, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.),

demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. [Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.]

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

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likely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

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retires.*

The following Resolution was
unanimously adopted by the
MSNJ Board of Trustees:

Whereas, Dr. Arthur Krosnick has announced
his retirement from the editorship of *NEW
JERSEY MEDICINE*; and



Dr. Krosnick in his Princeton office.



Arthur Krosnick, M.D.

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Whereas, Dr. Arthur Krosnick has served for 15
years as Editor of *NEW JERSEY MEDICINE* and
its predecessor *The Journal of the Medical So-
ciety of New Jersey*; and

Whereas, under the leadership of Dr. Arthur
Krosnick, our journal has achieved new stan-
dards of excellence; and

Whereas, our journal has received first place
awards in national competition for state medical
society publications, in two of the past three
years; now therefore be it

**Resolved, that the Medical Society of New
Jersey express its gratitude and appreciation to
Dr. Arthur Krosnick for the excellence of his
leadership of *NEW JERSEY MEDICINE/The
Journal of the Medical Society of New Jersey*;
and be it further**

**Resolved, that the Medical Society of New
Jersey commend Dr. Arthur Krosnick for his
long and untiring efforts on behalf of the Medi-
cal Society and our journal; and be it further**

**Resolved, that this Resolution be spread upon
the minutes of the Society, and be published in
NEW JERSEY MEDICINE; and that a copy, suit-
ably prepared, be presented to Dr. Arthur
Krosnick.**

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The consensus[†]:

Nearly three out of four physicians responding to the survey consider **INDERAL LA** their preferred beta blocker for hypertension—preferring to prescribe it before ACE inhibitors, calcium channel blockers, and alpha blockers. Forty-nine percent of these physicians also preferred to prescribe **INDERAL LA** before diuretics.

Nearly all physicians cited **INDERAL LA** for its good to excellent tolerability and rated **INDERAL LA** good to excellent in promoting patient compliance.

Surprising?

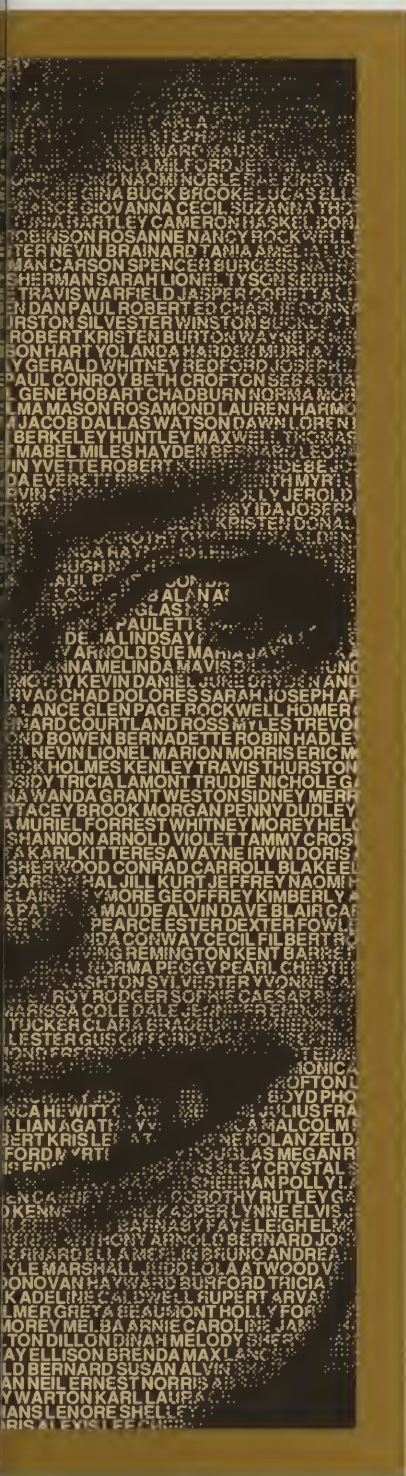
Not really. Evaluate **INDERAL LA** in your own practice and see. Expect your next **INDERAL LA** patient to feel like a million.

INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma.

ONCE-DAILY
INDERAL® LA
 (PROPRANOLOL HCl)
 LONG ACTING CAPSULES
 60, 80, 120, 160 mg

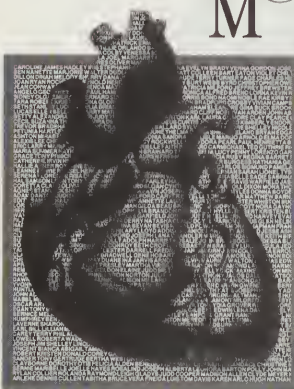
The one you know best keeps looking better

Please see next page for brief summary of prescribing information.



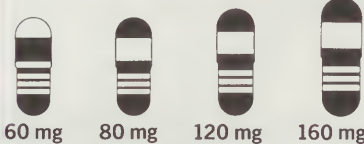
feel like a

MILLION



ONCE-DAILY
INDERAL LA
(PROPRANOLOL HCl)
LONG ACTING CAPSULES
60, 80, 120, 160 mg

The one you know best
keeps looking better *



BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL® LA brand of propranolol hydrochloride (Long Acting Capsules)

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3 , and decreasing T_3 .

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be cautioned that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return to increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL (propranolol HCl) is administered. The additive catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncope, ataxic or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbital, and rifampin accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and lidocaine have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paraesthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dream appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasisform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—Dosage must be individualized. Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—Dosage must be individualized. The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE— At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Wyeth-Ayerst Laboratories.

Reference:

1. Data on file, Wyeth-Ayerst Laboratories.

†Based on response of 4,120 participating physicians to questionnaire survey.

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INAUGURAL ADDRESS

PALMA E. FORMICA, M.D., OLD BRIDGE

Palma E. Formica, M.D., presented this Address at her inauguration on April 29, 1988, at the Annual Meeting of the Medical Society of New Jersey, at the Sheraton Meadowlands Hotel in East Rutherford.

Let me begin by saying "Thank you," thank you for the honor of being the 196th president of the

Medical Society of New Jersey. No one reaches this position alone. The support and encouragement of each of you, mentors, role models, peers, colleagues, family, and friends have made it possible for me.

My thanks also are extended to our past presidents. Each has given selfless and dedicated service for the betterment of the profession and the health of the people of this state. They have left their mark on the history of this Medical Society.

To my immediate predecessor, I extend a special word of appreciation. Harry Carnes is unique in so many ways. He set a collegial tone, sharing many of his presidential activities with the other officers. He has started much. I hope to give continuity to the programs underway, such as: The AIDS Task Force; the Seniors' Courtesy Program; involvement in the legislative arena; continued dialogue with the commissioners of health and insurance, as well as cooperation with the State Board of Medical Examiners. Membership recruitment and leadership development will continue.

As president of the Medical Society of New Jersey, I represent you. Your concerns, frustrations, and problems are ours. Together we can find solutions.

Today, we pursue our profession in many ways: as solo or group practitioners, as specialists and general-

ists, as researchers in industry and academic institutions, as administrators and as medical staff members, as teachers, and as students, just to mention a few.

There are potentials for division. The young against the older, the town-gown syndrome; those employed by institutions or groups; and the self-employed. Yet, in all this diversity, there is the unity of belonging to a professional organization which binds us all together, which acts as our advocate and champions the cause of our patients.

I ask you to celebrate with me the 222nd year of the Medical Society of New Jersey; to celebrate being physicians, and to celebrate being called to the profession of healing.

I know some of you may be thinking, "Celebrate"? What is there to celebrate? Times could not be worse for doctors. We are being manipulated, maligned, and maltreated by government, business, and even the public. Every day brings a new threat: the professional liability crisis, PRO sanctions, managed care; capitation, leveraged competition; mandatory assignment, and many more. We are blamed for the high cost of medical care. They say it is inappropriate, ineffective, and unwarranted. We are accused of being entrepreneurs, hucksters, and greedy fat cats interested only in our pocketbooks.

And you say "celebrate"?

My answer is a resounding yes. It is time for us to

announce publicly that we are proud to be physicians providing the best in health care. We know why we are physicians, for the benefit of patients.

PROFESSIONALISM

The most serious threat facing us today is the temptation to yield to those pressures and criticisms which would destroy our very professionalism. Do we still meet the qualifications of a professional?

A professional has a unique body of knowledge.

We recommit ourselves to preserving and advancing that scientific body of knowledge we call medicine. Despite our own frustrations, we must encourage the brightest and the best to follow this noble calling, and when they are accepted into medical school with its rigorous training, we must insist that striving for excellence is the hallmark of both the art and science of medicine. As role models and mentors, we must continue to be part of their training. Our specialty programs and residencies must not only provide state-of-the-art education but must respond to the needs of the people. Our goal in education must be to prepare ethical, competent, and caring practitioners. Every one of us has that responsibility.

Physicians have a lifelong obligation of learning, not only for our personal satisfaction and intellectual curiosity, but also for our patients so that we can "apply and advance scientific knowledge and make that information available" for the well-being and health of our patients and the public.

CODE OF ETHICS

A profession is governed by a code of conduct.

The ideals of our profession are embodied in the code of ethics dating back 2,400 years ago to Hippocrates, the Father of Medicine. At graduation, each of us took this oath. Its principles are just as valid today. We are doctors for patients, their welfare must come before our own. The World Health Organization sums it up clearly: "The health and welfare of patients shall be the first consideration, not allowing economics, politics, race, or religion to take precedence."

Our own American Medical Association has said: "Ethical statements are developed primarily for the benefit of the patient."

We believe a physician "shall be dedicated to providing competent medical service with compassion and respect for human dignity; and we shall deal honestly with patients and colleagues, respect the law and recognize a responsibility to seek changes for the best interest of patients, respect rights of patients and of colleagues, and safeguard confidences."

Throughout the ages we have promised to respect our teachers, to educate students, to place the good of the patient above all else, to do no harm, and to pursue the art in a spirit of collegiality and mutual respect.

We rededicate ourselves to these ideals. We stand tall and unashamed of committing ourselves to others, protecting the patient from harm when he is most vulnerable and defenseless. The very code that binds us as physicians is more demanding than any law, rule, or regulation of the marketplace. The skeptics may doubt us; they always have. Our actions must drown out the clamor of our critics.

OUR CHALLENGES

Autonomy. The most critical challenge we face today is the intrusion of third parties into medical decision making. The right of professional autonomy is fundamental to the doctor-patient relationship and quality care.

Will we yield this basic freedom to government, business, or third-party payors? Will we have the courage to say, "No more! The good of my patient comes first"? Every time we intervene on a patient's behalf, we make that point.

Self-regulation. With rights and freedom in decision making comes the obligation of self-regulation and accountability. Physicians alone have the expertise to set standards, evaluate treatment modalities, and review each other. Every time we are reviewed or engage in peer review through various hospital and government and medical society review, we are regulating ourselves. Whenever we discover and report an impaired or incompetent colleague, we acknowledge our responsibility to the profession and to the public.

A license to practice is a privilege. Those who use it to exploit patients must be reported immediately, and disciplined by the appropriate agencies.

Dr. Edmond Pellegrino has said, "Medicine needs persons habitually disposed to do the right and good thing—even when they are not being watched. We are called to a higher standard of performance."

Accountability. Essential to self-regulation and professional autonomy is accountability. The entire thrust of the quality assurance programs is to demonstrate that patient care is being provided competently, appropriately, and in a cost-effective manner. As the profession seeks to find a mechanism to demonstrate quality, we physicians must be in the vanguard.

We have no fears of being accountable. More than any other profession, medicine has led the way. However, we will not sacrifice quality and humanity on the altar of cost containment.

COVENANT OF CARING

The unique aspect of being a physician is the doctor-patient relationship. It is the touchstone of our professional commitment. It is not a contract between the provider of a commodity purchased by a consumer. How instinctively we are repulsed by this definition of the social planners. It is the most sacred bond between the physician and the patient. It is a relationship—a covenant of caring. As physicians, we are privileged to serve; to be a part of a healing process, to care for those who are burdened by pain, disease, and suffering. We—the patients and us—are "connected" in joys and sorrows, hopes, and frustrations.

Physicians bring the gifts of expertise, skill, knowledge, understanding, and compassion. Our patients gift us with trust, affirmation, and meaning. Serving people—one at a time—is what we are all about.

We pledge to our patients and to each other our dedication to this covenant of caring. Are we still professionals? Do we meet the qualifications? We will not be discouraged by the problems facing medicine. There have been others in the past. With persistence and commitment, we will prevail again.

The art and profession is not dead!

Come celebrate with me the joy of being a physician.



BETTER CARE MEANS GOING THAT EXTRA MILE.

From the moment patients arrive at The Mid-Atlantic Kidney Stone Center, we want them to feel comfortable and at ease. We begin by showing them a videotape explaining the lithotripsy treatment process, followed by a tour of our facility. Along the way we introduce them to the staff who will be providing their care.

We then make every effort to answer patient questions and address their concerns. Even though they are in our care for

just a few hours, we do our best to make the experience as pleasant as possible. Patients appreciate the personalized care at the Mid-Atlantic Kidney Stone Center.

In nearly three years of experience as a lithotripsy service, we have treated more than 3000 kidney stone patients from New Jersey, Eastern Pennsylvania, metropolitan New York and Del-

aware. We believe that our expertise makes us uniquely qualified to serve you and your patients.

If needed, we offer complimentary transportation and hotel accommodations for patients traveling to the Mid-Atlantic Kidney Stone Center. To find out more about our service, or how you can obtain staff privileges at the Mid-Atlantic Kidney Stone Center, call (609) 983-7337. Outside of New Jersey, call (800) 53-LITHO.



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KIDNEY STONE CENTER**

A LITHOTRIPTER SERVICE
One Brick Road, Suite 103
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FAREWELL ADDRESS

HARRY M. CARNES, M.D., AUDUBON

Dr. Harry Carnes presented this farewell address at the Annual Meeting of the Medical Society of New Jersey on April 29, 1988, at the Sheraton in East Rutherford.

This will be a bread and butter discussion of issues MSNJ has faced this year, and a brief assessment of the future as your president views it.

It has been a rather exciting year at MSNJ. We have scaled the heights (as exemplified by Assembly committee rejection of mandatory fee assignment) and plumbed the depths (as evidenced by our lack of enactment of major tort reform legislation). Yes, we have known victory and defeat, but—on balance—I feel confident that we are pursuing the proper course for our patients and our profession.

I've always been loath to take your time in discussion of general issues. However, as your president, I think I have the prerogative; indeed, the duty, to do just that. I want to convey to this house the general impressions that I've gleaned from traveling, listening, and speaking throughout this and neighboring states.

Positive areas this year for medicine are:

1) **Rejection of mandatory Medicare assignment** coupled with the statewide development of programs to assist disadvantaged senior citizens at the county level. We promised this to the Assembly Committee on Health and Human Services last May and—with statewide county support—we have fulfilled that promise.

2) **Formation of an AIDS Task Force** to provide testing guidelines and educational information for physicians throughout the state. Our entire symposium

on Sunday morning will involve AIDS. It is the number one health issue in New Jersey, and there isn't any number two. I hope each of you will make the effort to attend. A statewide governor's task force has been recommended to combat this most horrendous epidemic of our time.

3) **Substantial Medicaid fee increase** in the near future. Physician support is needed to place New Jersey in compliance with federal guidelines. Federal support (with feds supplying half the money) is mandatory for continuation of the program; thus, the promised physician fee increase. Continuing firm negotiations will be required with the Department of Health and Human Services, the Legislature, and the governor's office.

4) **Persistently increasing political involvement** of MSNJ. This political involvement enables us to do many things, not the least of which is to keep the allied health professions at bay. This large group consists of: optometrists, physical therapists, nurse practitioners, chiropractors, nurse midwives, physician assistants, and pharmacists. Some of these people want to practice medicine without going to medical school. Our legislative support allows us to make the argument that the health and well-being of the citizens of New Jersey should be in the hands of those who were given a plenary license to perform that very service: namely, the medical and osteopathic physicians of this state.



Harry M. Carnes

In my opinion, this Society possesses the talent, the resources, and most importantly—the will—to be a major political force in this state, now and in the future. We really have no alternative.

Some of the less favorable aspects of the past year have been:

1) **The inability to move significant tort reform** in the Judiciary Committee of the Senate. Our structured settlement and statute of limitations bills have languished in that committee. These bills will be reintroduced and renewed efforts made to have them passed. We were able to obtain a joint and several liability and collateral source bill.

2) **The inability of this Society to significantly increase membership** in general (and, in particular, women and other minority groups). As you may remember, it was my number one priority as I assumed this office last May. With Doctor Formica's help and committee support, we have made progress in this area—but much remains to be done. This will be an ongoing task for future administrations.

Discussing this subject, I would like to make two observations: graduates of non-U.S. schools received strong support from this House of Delegates on the issues of equality in testing, and in having their own special section in the AMA House of Delegates. Our incoming president and first vice-president are graduates of non-U.S. schools. These facts should help us in recruiting new members and it should be stated that this is not an exclusive society. Secondly, I would like to state the obvious: this Society is only as strong as its component societies. This is why I wanted every

county president recognized today. The work done throughout the state by our county leaders is enormous. Their accomplishments provide the platform on which we build at the state level. A recent example is the Senior Citizen Courtesy Program. By establishing a network of these programs throughout the state, we have blunted the thrust of that persistent, odious legislation. I do not think it is necessary or even healthy that state leaders and individual county leaders agree on every issue, but we can and must develop a consensus and then act in a manner that will be beneficial to the entire membership.

3) **SCI report** was an unexpected, bitter blow. We were castigated for a program that we had initiated and helped fund. The program was a prototype for the entire country. The negative aspects of the report led to headlines in all the major newspapers, and lead stories on every television channel and radio station in this and neighboring states. Every column and editorial was negative, without exception. Legislative leaders grabbed the story and called for public hearings. The comments always were the same—it was a case, they said, of professionals protecting each other—the conspiracy of silence goes on. Your Board of Trustees thought we were in a no-win situation, and—in an effort to defuse the issue—we chose to remain silent.

The damage done by the report was twofold: First, the commission subtly equated malpractice with incompetence, and impairment with incompetence. This, as you know, is the same story that we heard from the commissioner of insurance. It is simply not true. Some of our finest physicians have malpractice suits against them—and impaired physicians are most commonly incompetent only in the final stages of impairment. Secondly, the commission recommended mandatory reporting to the State Board of Medical Examiners for discipline, causing—in effect—what could become a police state. We considered it a dangerous recommendation. We think it would decrease the reporting of impairment drastically. Our goal is rehabilitation with confidentiality to all impaired physicians, and not public censure. Our course of action was to hire Herbert J. Stern, a prominent attorney with excellent credentials. He was a former federal prosecutor in northern New Jersey, and a federal judge for ten years. It is his task, working closely with Vincent Maressa, David Canavan, and the Board of Trustees, to present our case to the Legislature. It will be no small task, and, I think, will defy easy solution. The State Board of Medical Examiners also is actively involved in legislation on this issue. It is hoped that we can work in concert on this serious problem so that we may achieve our common goal—which is to guarantee that every citizen of New Jersey receives medical care from a competent physician.

4) **Harvard Relative Value Study** is the most important item on the medical horizon, certainly as perceived by the AMA. The AMA thought it important enough to invite the presidents and executive directors of all the state societies to Chicago some few weeks back, in order to keep everyone apprised of the situation as it now exists.

The discussion with AMA leaders in Chicago began by asking those assembled if they thought there would

be changes in reimbursement for physicians, and escalation of involvement by government and other third parties in the next five years. When we all gave a positive response, this led to the conclusion that the relative value fee may be the best and the fairest that we can get. The alternative to this is capitation and physician DRGs, which HCFA wants. HCFA prefers capitation because it controls volume. This is one item that keeps medical inflation rising at several times the national level.

The Harvard Relative Value Study was mandated by Congress, funded by HCFA, with the AMA as a subcontractor. HCFA will receive the study in July 1988, and must release it to the Congress in August 1988. At that time, it will become public information. The AMA will give the specialty societies an opportunity to assess the accuracy of the study. Hopefully, it will be presented to the AMA House of Delegates at their interim meeting in December 1988.

This study pits specialty against specialty. We must maintain unity to combat the almost certain problems that we will face. If we continue to speak and negotiate with one voice, we will be a formidable force to deal with. Divided—the government will hand us our heads. You can bet that “divide and conquer” will be the order of the day. Strong, consistent leadership will be *de rigueur*. My best guess is that the future of the AMA as preeminent spokesman for medicine may be at stake. It is my perception that the AMA thinks so, too, and that its leaders intend to be well prepared for the fight.

In conclusion, permit me to give my heartfelt thanks to the officers, Board of Trustees, all committees of the Society, the speakers, and reference committees of this convention—for the time and effort expended to make this year a success. I do not think some members realize the time and talent given freely on behalf of the

Medical Society of New Jersey, but as your president, I can tell you that it is immeasurable.

The same heartfelt thanks go to the staff. They are a talented, industrious, and pleasant group who tolerated the antics of their president with grace and good humor. I think they know I appreciated their superb efforts.

This Society should be aware of the fact that professionally we are respected, not loved, in every area of the state. I think that is high tribute, and it follows that—as your representative—I was received graciously throughout the state. I believe that we possess far more power than we at times perceive, but with that power goes responsibility to act prudently.

I want to remind you that we must remain true to our highest ideals—never better illustrated than in our present AIDS situation. If we maintain concern for patients above self, our profession will just grow in stature and get stronger.

While our patients are given competent and compassionate care—let the message ring loud and clear throughout the land—we shall not relinquish control of our profession to any group, whether it be hospital, government, entrepreneur, or anyone else. We shall fight for causes that preserve and protect medicine without apology. This noble profession is far too precious to give away.

On a personal note, I can tell you that others with far more talent than I have occupied this office in previous years, but no one ever enjoyed it more. I leave you with profound thanks for giving me the opportunity to serve.

I could paraphrase an old torch song to express my feelings:

Every day was Sunday,
every town was Paris,
and every month was May.



SLOW-K

The World's Most Popular K*

Slow-K[®]
potassium chloride
slow-release tablets
8 mEq (600 mg)

It means "dependability" in almost any language

*Based on worldwide sales data on file, CIBA Pharmaceutical Company.
Capsule or tablet slow-release potassium chloride preparations should be reserved for patients who cannot tolerate, refuse to take, or have compliance problems with liquid or effervescent potassium preparations because of reports of intestinal and gastric ulceration and bleeding with slow-release KCl preparations.

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Slow-K[®]
potassium chloride
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For patients who can't or won't tolerate liquid KCl.

*The most common adverse reactions to potassium salts are gastrointestinal side effects.

†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

C I B A

References: 1. Data on file, CIBA Pharmaceutical Company. 2. Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. 3. Skoutakis VA, Carter CA, Acchiardo SR: Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

Slow-K[®]
potassium chloride USP
8 mEq (600 mg)
Slow-Release Tablets

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)

INDICATIONS AND USAGE

BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS

Hyperkalemia (See OVERDOSAGE).
In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS

General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients

Physicians should consider reminding the patient of the following:

To take each dose without crushing, chewing, or sucking the tablets.

To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.

To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions

Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 mEq/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitals, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

HOW SUPPLIED

Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K)

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CLINICAL CORRELATES AND DIAGNOSTICS IN CAROTID VASCULAR DISEASE

ROBERT A. BAZEWICZ, M.D., LARRY B. SANDLER, JOSEPH D. COHN, M.D., LIVINGSTON*

Results of noninvasive cerebrovascular studies were compared to those of contrast imaging of the internal carotid artery. Doppler spectral analysis was as accurate as contrast angiography and more accurate than digital subtraction angiography in assessing the extent of internal carotid artery stenosis.

Until recently, there was no question as to the need for angiography in the preoperative evaluation of patients undergoing carotid endarterectomy. Even with refinements in the techniques of standard contrast arteriography and the development of digital subtraction angiography, contrast imaging of the carotid vasculature carries a recognized overall morbidity of 5 to 15 percent with neurologic sequelae making up about 1 percent of the overall morbidity.¹⁻⁴ The development of noninvasive vascular assessment utilizing Doppler spectral analysis, oculoplethysmography-Gee (OPG), and supraorbital bidirectional Doppler flow studies has led to increasingly accurate evaluations of stenotic lesions of the internal carotid artery (ICA).⁵⁻⁸ B-mode real-time imaging also has emerged as a reliable means of assessing stenotic lesions of the carotid arteries.⁹

Utilizing a multimodality approach in evaluating carotid arterial disease, carotid endarterectomy has been performed in a select group of patients without the use of preoperative contrast angiography.^{9,10} This concept prompted us to correlate the results of the various noninvasive vascular studies with symptomatology and angiography.

METHODS AND MATERIALS

Noninvasive carotid vascular studies consisting of

supraorbital bidirectional Doppler flow analysis, ocular pneumoplethysmography-Gee, B-mode ultrasound imaging, and Doppler spectral analysis were carried out on 366 vessels examined consecutively over an eight-month interval in the noninvasive Vascular Laboratory at Saint Barnabas Medical Center in Livingston. Cerebrovascular symptomatology and findings on both conventional and digital subtraction angiography were compared against data obtained by spectral analysis (SA). Patient referrals for noninvasive carotid study were for asymptomatic bruits, nonlateralizing neurologic symptoms, transient ischemic attacks, and lateralizing neurologic deficits.

Using a 5 MHz transducer with the signal displayed on a real-time spectrum analyzer and a B-mode ultrasonic imager,** the degree of internal carotid artery stenosis was assessed following the guidelines set forth by Strandness.⁵ Supraorbital bidirectional Doppler flow analysis† was performed on 272 of the vessels

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**Advanced Technology Labs, Models 459-C spectrum analyzer and 860-C B-mode imager.

†Parks Electronics Dual Frequency Bi-Directional Doppler model 1010-A.

TABLE 1

Internal Carotid Artery Stenosis
Neck Bruits and Doppler Spectral Analysis
(n = 366 vessels)

	Spectral Analysis Percent Stenosis				
	0-15%	16-49%	50-79%	80-99%	100%
Vessels	229	70	55	9	3
% Bruits	31	44	67	78	0

P<0.001

TABLE 2

Internal Carotid Artery Stenosis
Neck Bruits and Doppler Spectral Analysis
(n = 366 vessels)

	Less Than 50% Stenosis	Greater Than 50% Stenosis
Bruit	99	46
No Bruit	202	19

studied.^{11,12} Two-hundred ninety-five vessels were studied by ocular pneumoplethysmography.* The methods of examination and significance of the results were those outlined by Gee and coworkers.^{13,14}

Contrast imaging was performed on 63 of the vessels within one month of the noninvasive evaluation. Conventional biplanar arteriography was performed on 53 of the vessels.** Intra-arterial digital subtraction arteriography (IADSA) was performed on 10 of the vessels.† Percent linear stenosis was determined from these contrast images using the following formula: % Stenosis = D-d/D (100), where "D" represents the averaged diameter of the first normal portion of the internal carotid artery distal to the stenotic lesion and "d" represents the averaged diameter of the area of greatest stenosis measured on a lateral and an oblique view of the vessel. All carotid contrast imagings were performed at the discretion of the referring physician and, therefore, do not represent a randomized population. The angiograms were reviewed and interpreted by a radiologist as well as the authors who were unaware of the results of the noninvasive studies. Significant discrepancies between the noninvasive results and those of contrast arteriography and digital arteriography then were evaluated retrospectively.

RESULTS

An audible neck bruit was noted in 145 of the 366 vessels evaluated and, when the completely occluded vessels were excluded, predicted the presence of ICA stenosis greater than 50 percent by SA (Tables 1 and 2) with a 71 percent sensitivity and a 67 percent specificity for an overall accuracy of 67 percent (*P*<0.001). A history of lateralizing sensory and motor symptoms,

amaurosis fugax, or syncope was obtained from 195 patients in the study population but did not correlate with ICA stenosis of greater than 50 percent.

OPG was compared to Doppler spectral analysis in 295 vessels with results appearing in Table 3. OPG was found to be a sensitive indicator of ICA stenosis greater than 80 percent by SA, sensitivity 100 percent, specificity 88 percent, with an overall accuracy of 88 percent (*P*<0.001). Supraorbital bidirectional Doppler flow analysis (SOF) was compared to SA in 272 vessels and the results appear in Table 4. SOF was a less sensitive (64 percent) indicator of stenotic disease greater than 80 percent than was OPG (100 percent); however, it maintained a higher specificity (95 percent) for an overall accuracy of 94 percent in predicting stenosis greater than 80 percent (*P*<0.001).

The results of selective contrast arteriography correlated well with those of SA in 53 vessels and appear in Table 5. The correlation coefficient of SA compared to contrast arteriography was 0.95 (*P*<<0.0001). No occluded vessels were misinterpreted by Doppler spectral analysis. Two contrast angiographic studies were misinterpreted on initial reading; however, retrospective review demonstrated the presence and degree of stenosis predicted by SA. These cases are cited below. Digital subtraction angiography was performed on ten vessels (Table 6) and did not correlate as well with the results of SA as did the selective contrast angiographic studies (*R*=0.53, *P*<0.20 versus *R*=0.95 *P*<<0.0001). There were no neurologic or renal complications among these angiographically studied patients.

CASE REPORTS

A 76-year-old male presented with a left carotid bruit and an episode of expressive aphasia occurring two weeks prior to study and lasting 24 to 36 hours, with subsequent complete resolution. On physical examination, he exhibited a monophasic systolic left carotid bruit and mild hypertensive fundoscopic changes. Noninvasive vascular studies revealed an 80 to 99 percent left internal carotid artery stenotic lesion on SA with SOF reversal and an ipsilateral 10 mm Hg pressure deficit on OPG; B-mode imaging was unable to locate a plaque to explain the above findings, but did note a tortulous ICA. The initial reading on contrast arteriography was "normal study"; however, retrospective review of the films, with knowledge of the noninvasive results revealed a 90 percent occluding "web" in the midpoint of the tortuous vessel. This was

*Electro-Diagnostic Instruments Model OPG-4 Ocular Pneumoplethysmograph.

**Picker Angicon Vascular Procedures Imaging System.

†Diasonic DF-100 Digital Fluorographic Imaging System.

TABLE 3

Internal Carotid Artery Stenosis
Neck Bruits
Ocular Pneumoplethysmography-Gee and Doppler Spectral Analysis
(n = 295 vessels)

	Percent Spectral Analysis Stenosis				
	0-15%	16-49%	50-79%	80-99%	100%
Vessels	183	64	42	5	1
% Abnormal OPG	8	19	21	100	100

$P < 0.00001$

TABLE 4

Internal Carotid Artery Stenosis
Supraorbital Bidirectional Doppler Flow and Doppler Spectral Analysis
(n = 272 vessels)

	Percent Spectral Analysis Stenosis				
	0-15%	16-49%	50-79%	80-99%	100%
Vessels	164	52	45	8	3
% Abnormal Flow	4	8	2	63	67

$P < 0.00001$

TABLE 5

Internal Carotid Artery Stenosis
Contrast Arteriography and Doppler Spectral Analysis
(n = 53 vessels)

% Angiographic Stenosis	Doppler Category				
	A/B	C	D	D+	E
0-15%	7	2			
16-49%	2	5	2		
50-79%		1	20*		
80-99%		1		7	
100%					6

*2 angiograms positive on review

$R = 0.95$

$P < 0.0001$

TABLE 6

Internal Carotid Artery Stenosis
Digital Subtraction Angiography and Doppler Spectral Analysis
(n = 10 vessels)

% Angiographic Stenosis	Doppler Category				
	A/B	C	D	D+	E
0-15%	1		1		
16-49%	1	2			
50-79%	1		2		
80-99%			1	1	
100%					

$R = 0.53$ $P < 0.20$



Figure 1—Selective carotid arteriogram demonstrates a tortuous left internal carotid artery. A nearly occluding internal carotid web (arrow) is visualized only on this oblique view.

initially misinterpreted due to the column of contrast in the external carotid artery overlying the point of stenosis on all but the oblique views (Figure 1).

A 68-year-old female presented with bilateral neck bruits, vague history of lightheadedness, and left-sided numbness and weakness of indeterminate onset and chronicity. Examination demonstrated soft bilateral systolic carotid bruits. Eye fields revealed changes consistent with long-standing hypertension and previous right surgical aphakia. Her heart rhythm was regular and there was no murmur. Noninvasive studies of both carotid arteries revealed: right ICA 0 to 15 percent stenosis by SA with normal SOF and an OPG pressure of 133 mm Hg; left ICA 50 to 79 percent stenosis by SA with normal SOF and OPG pressure of 124 mm Hg. She underwent arch and carotid contrast imaging using IADSA to reduce the contrast load, and was found to have no demonstrable stenosis. Because of poor resolution, selective carotid arteriography (CA) of both carotid arteries was performed and revealed a 74 percent stenosis high in the left ICA which, even in retrospect, could not be found on the IADSA studies. The right ICA had a 15 percent stenotic lesion at the bifurcation of the common carotid artery (Figure 2).

DISCUSSION

The significance and management of asymptomatic carotid bruits remain controversial issues. An increased risk of stroke has been ascribed to patients with asymptomatic bruits and angiographically documented stenosis,¹⁵ yet many patients with asymptomatic bruits are not at increased risk for stroke from their carotid disease.^{16,17} Arteriographic demonstration of a flow significant stenotic lesion has been shown to



Figure 2—Selective left carotid arteriogram illustrates a high-grade stenosis of the upper cervical portion of the internal carotid artery (arrow). This stenosis was not demonstrated on an intra-arterial digital subtraction angiogram.

place one at an increased risk for stroke;¹⁵ however, arteriography is not without complications.^{1,4} Contrast-induced renal failure is one of the most important complications of conventional arteriography and occurs in approximately 1 percent of all patients so studied, an increased incidence being noted in patients with diabetes, chronic renal insufficiency, hypertension, and extracellular volume depletion.^{18,19} Moreover, in diabetics, the incidence is doubled and if the creatinine level is above 2 mg/dl, the risk of acute renal failure may be as high as 33 percent.¹⁹ Neurologic sequelae occur in 0.5 to 1.0 percent of most reported series. Digital subtraction angiography utilizes small amounts of contrast material, thereby lowering this risk, and has been thought to provide images comparable in clarity to conventional angiography.²⁰ Others report poor resolution and a tendency to underestimate the severity of the carotid disease utilizing IADSA.²¹ Our experience favors the findings of the latter, i.e. that the severity of the disease tends to be underestimated. However, it should be noted that this conclusion is based on images obtained from early imaging systems. The newer, state-of-the-art, digital subtraction imaging systems appear to provide studies with far better resolution and it remains to be seen if these studies will correlate as well with SA as does conventional arteriography.

With contrast arteriography as a standard for comparison, SA provided hemodynamic information which predicted the extent of ICA stenosis with a correlation coefficient of 0.95. This is similar to the results of other reported series with a correlation of 85 to 95 percent.^{9,21,22} SOF and OPG were less accurate in predicting the degree of stenosis, but OPG detected all steno-

ses greater than 80 percent in our series. It is significant to note that no completely occluded vessel was misinterpreted using this combined approach, and no vessels with high-grade stenosis were mislabelled as 100 percent occluded.

Our results demonstrate that most cases involving flow significant stenosis of the surgically accessible portion of the internal carotid artery can be reliably detected by noninvasive vascular testing. The presence of an audible neck bruit, whether symptomatic or not, accurately reflected stenosis greater than 50 percent while subjective symptoms did not. Since SA, OPG, and SOF all quantitate the extent of disease based on alterations in flow dynamics within the carotid artery, it stands to reason that a bruit (the result of a flow significant lesion) should herald a stenotic lesion and be able to be detected by these means. Of significance, also, is the ability to distinguish between stenoses of the internal carotid artery from the external and common carotid arteries. Subjective symptoms, on the other hand, may be the result of one of a myriad of causes, only a few of which involve extracranial carotid arterial disease. Symptoms, therefore, in the absence of a bruit did not correlate well with any carotid arterial disease demonstrable by these studies.

B-mode imaging is utilized for locating stenotic lesions; however, in a series of 89 vessels in which images from B-mode ultrasonography were compared to those specimens obtained at carotid endarterectomy, O'Donnell and coworkers demonstrated that B-mode imaging can provide an accurate picture of stenotic lesions and also define the characteristics of ulcerated plaques.²³ We have not found B-mode ultrasonography to be a sensitive means of defining the anatomy of ulcerated plaques because adequate resolution of the vessel's medial wall has been a limiting factor. With only sector scanning available, we still favor contrast imaging over noninvasive studies in the evaluation of nonstenotic carotid arterial lesions. SA, SOF, OPG, and B-mode imaging in combination, however, made the predictive value of our noninvasive studies sufficiently accurate to preclude the need for contrast imaging in assessing stenotic lesions greater than 80 percent. Both cited cases of discrepancies between contrast imaging and noninvasive studies involving stenotic lesions of the ICA were diagnosed by the noninvasive vascular studies but not initially appreciated on contrast angiography. It was only after the information from the noninvasive studies was reviewed that the lesions were noted.

CONCLUSIONS

Audible neck bruits more accurately reflect the presence of ICA stenosis than does the presence of subjective neurologic symptoms. Spectral analysis is an accurate means of measuring the extent of stenotic lesions in the internal carotid artery and correlates well with selective biplanar contrast arteriographic studies. IADSA underestimates the extent of stenoses and correlates poorly with the findings of SA. Nonstenotic lesions were most reliably assessed with contrast imaging. The combined use of OPG and SA may be sufficient to reliably document ICA stenosis greater than 80 percent and preclude the need for diagnostic contrast imaging of such lesions.

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'DYAZIDE' AS WRITTEN.

* Not for initial therapy. See brief summary.

Before prescribing, see complete
prescribing information in
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The following is a brief summary.

* WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or

without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin (ACTH)). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The

following may occur: transient elevated BUN or creatinine or both; hyperglycemia and glycosuria (diabetic insulin requirements may be altered); hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak[™] unit-of-use bottles of 100.

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AEROALLERGEN PREVALENCE IN NEW JERSEY

LEONARD BIELORY, M.D., AND CLEMENCIA DIAZ, R.T., NEWARK*

Aeroallergens cause IgE-mediated disorders and their presence correlates with the development of many allergic symptoms. In New Jersey, tree, grass, and weed pollens are released sequentially from February through November, while mold antigens are present from the winter thaw through the first frost.

Type I (IgE-mediated) hypersensitivity reactions which are manifested in allergic asthma or rhinoconjunctivitis develop within minutes after exposure to an antigen such as pollen or mold particles.^{1,2} Pollen, a fine powder of airborne allergens (aeroallergens), are male reproductive structures of seed-bearing plants.³ The plants, which use the wind as the means for fertilization, usually produce extremely large volumes of pollen and, consequently, are a source of a significant quantity of inhaled antigens.^{3,4} Therefore, the Division of Allergy and Immunology, as part of a national survey under the auspices of the American Academy of Allergy and Immunology (AAAAI)—Pollen and Mold Committee and sponsored by the National Institutes of Health, National Institute of Allergy and Infectious Diseases, studied the prevalence of aeroallergens in northern New Jersey for 1987 at UMDNJ-University Hospital/New Jersey Medical School.

METHODS

Aeroallergen collection, with the AAAI-approved rotating air impactor (Rotorod, Ted Brown Associates, California) were evaluated daily beginning March 1, 1987. Lucite rods coated with silicone grease were rotated for 30 seconds every ten minutes at a fixed speed during a 24-hour interval. The rods were removed,

stained with Hansel's stain, and the pollen and mold particles counted over a fixed distance. The results were tabulated and reported as the average number of pollen or molds particles per cubic meter of air sampled.^{5,6}

A total count of less than 100 is considered low; 100 to 500 is moderate; 500 to 1,000 is high; and greater than 1,000 is extremely high. A pollen count for a specific pollen in excess of 10 per cubic meter is considered significant.

The pollen counts were performed daily at 8:00 A.M., Monday through Friday. The examination performed on Monday reflected the total collection from Friday (8:00 A.M.) through the weekend until Monday (8:00 A.M.). The Monday count, therefore, was an average of three days (Friday, Saturday, and Sunday) and was divided by three to give the average daily count for the weekend.

RESULTS

In general, pollination of the major plants occurred in sequence: trees in the late winter through spring,

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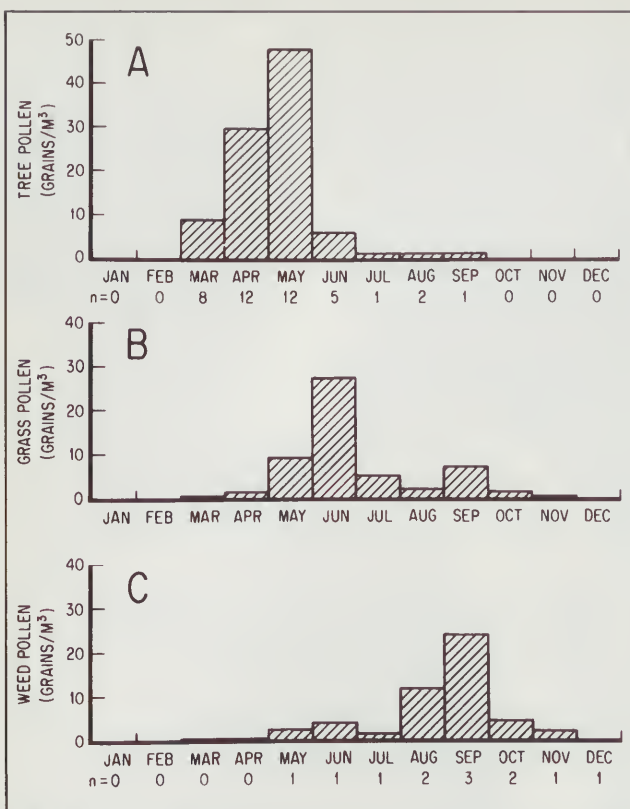


Figure 1—Average pollen counts are reported for trees (A), grasses (B), and weeds (C) during each month. Pollination of the trees, grasses, and weeds appeared sequentially from February through November with overlap between the species. (Below each month, N = number of different species included in the average monthly tree and weed counts. Grass species were not differentiated on their morphology.)

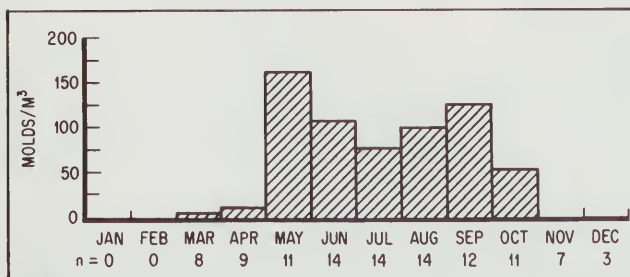


Figure 2—Average mold particles reported during each month. Mold growth increased after the winter thaw and persisted through the first frost (March-November).

grasses in the spring through early summer, and weeds in the summer through early fall. The release of mold spores was noted as early as the first winter thaw, when moisture permitted mold growth, through the first frost.

Trees started to pollinate by the beginning of March and continued through the beginning of May (Figure 1A). The major tree pollens were from the elm trees which appeared first, and then later in the year by the birch trees.

Grasses started to pollinate during the middle of March and continued through the beginning of July. A second peak in pollen release occurred during September (Figure 1B). Types of grasses were not identified.

Weeds started to pollinate in the middle of May and continued through October. The major weed pollens

identified were from *Plantago*, *Chenopodium*, and *Ambrosia* (ragweed) species (Figure 1C). Specifically, ragweed pollination began in the middle of August and continued through the beginning of October.

Mold spores initially were recorded at the middle of the tree pollinating season and continued throughout the year until the late fall. Mold spores exceeded pollen particles 10- to 100-fold (Figure 2).

DISCUSSION

Aeroallergens are relatively large and complex materials, e.g. pollens, molds, house dust mites, animal dander, that are capable of inducing a type I IgE-mediated hypersensitivity (allergic) reaction leading to the activation of mast cells and the subsequent release of inflammatory mediators in susceptible persons.¹⁻⁴ These particles contain many molecular components and only some are antigenic. These antigenic portions are mainly proteins with a molecular weight of 3,000-40,000 daltons and are 2 to 60 μm in diameter.^{3,4,7} The majority of these particles come into direct contact with the ocular, nasal, and pharyngeal surfaces, while only 80 percent of those particles less than 10 μm reach the bronchial mucosa.^{4,8} Asthma may be caused by the direct contact of the smaller particles or from the stimulation of a bronchial reflex by nasopharyngeal receptors.⁹

Previously, physicians treating patients with allergic conditions in New Jersey had to rely on general botanical information of the known flora found in this geographical setting. However, we attempted to document the actual types and timing of pollens found in the New Jersey environment. Although pollens can be obtained from a variety of plant life, not all pollen grains appear to produce an allergic response.^{3,4} The pollen-producing plants which are most troublesome in inducing allergies can be classified into three main categories: grasses, weeds, and trees.^{3,4} The amount of pollen does not appear to be the major factor of an allergic response since 100- to 1,000-fold more pine pollen is released than ragweed pollen; yet over 75 percent of allergic patients are sensitive to ragweed.^{3,4,10} In the United States, the grasses and the weeds (ragweed) are major culprits in the production of allergies: rhinoconjunctivitis and extrinsic asthma.^{3,4,11} Correlation of particle counts with clinical symptoms on a given day must be cautiously interpreted since allergic patients have different levels of sensitivity.⁴ This study was undertaken to determine the prevalence of such clinically significant aeroallergens in order to better assist the New Jersey physician in the education and treatment of these allergic patients.

A number of methods, gravitational or volumetric, are available to identify and quantify the various pollens and molds released into the atmosphere.^{4,6} Large particles (greater than 20 μm in diameter) are adequately measured by gravitational methods, but for research purposes, the more accurate volumetric techniques have been employed. Therefore, the American Academy of Allergy and Immunology—Pollen and Mold Committee approved the volumetric technique, rotating air impactor (Rotorod), for their national survey of aeroallergens.

The pollen of anemophilous, wind-pollinating, as compared to the entomophilous, insect-pollinating,

trees are the principal causes of respiratory allergy during the late winter and spring.^{3,4} Each tree genus produces pollen morphologically distinct from that from any other genus.^{3,4} In New Jersey, the predominant genera are elm (*Ulmus* sp.) and birch (*Betula* sp.). In general, the pollinating period for each species was several weeks.

Grass pollen are the principal causes of allergic symptoms during the spring and early summer.^{3,4} In New Jersey, there also appears to be a second pollinating season at the end of the summer in September. It is difficult to distinguish grass pollen solely on the basis of morphology.^{3,4} Consequently, the importance of individual species is based on the total grass-pollen counts and correlated with the regional prevalence of individual grass species. In New Jersey, blue grass, orchard grass, timothy grass, and red top grass predominate. The frequency and severity of allergic symptoms to grass pollens ranks second as compared to weeds in the United States.^{3,4} In other parts of the world it is the leading offender.^{3,4}

Although there is an extensive list of plants that can be considered weeds, ragweed (*Ambrosia* sp.) is the single most important cause, quantitatively and qualitatively, of seasonal allergic rhinitis (hay fever) in the United States.^{3,4} In New Jersey, ragweed pollinated in the late summer (mid-August) through early fall. Other weeds identified were lamb's quarters (*Chenopodium* sp.), cocklebur (*Xanthium* sp.), plantain (*Plantago* sp.), and dock sorrel (*Rumex* sp.).

Mold sensitivity in allergic patients is characterized by sporadic exacerbations during periods of maximal growth or concentrated exposures. As noted in increased asthmatic episodes in patients with allergic bronchopulmonary aspergillosis, as well as other allergic complaints in patients raking leaves, or visiting a farm, molds exist in almost every environment.¹² Their airborne presence was noted during the initial exposure of moisture during the winter thaw and continued through the first frost at which time the molds sporulate, producing a large airborne antigen load. However, molds may be found in many homes causing perennial allergic symptoms.¹³

CONCLUSION

The primary treatment modalities for allergic reactions are avoidance, pharmacotherapy, and immunotherapy (hyposensitization). Immunotherapy commonly is utilized in patients with unavoidable sustained

exposures, and brings symptomatic relief to over 80 percent of patients.^{11,14-17} The antigens used in the immunotherapy treatments are guided by the positive immediate skin tests and the prevalence of specific allergens in the immediate environment during the height of the patients' symptoms.

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For moderate-to-severe vasomotor symptoms and for osteoporosis

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The appearance of these tablets is a trademark of Ayerst Laboratories.

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream, in a nonliquefying base

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA. Three independent, case-controlled studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case-controlled studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semi-annual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equi-estrogenic doses.

2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY. The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing, in later life, a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb-reduction defects. One case-controlled study estimates a 4.7-fold increased risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17 α -dihydroequilin, together with smaller amounts of 17 α -estradiol, equilin, and 17 α -dihydroequilin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe vasomotor symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) Osteoporosis (abnormally low bone mass). Atrophic vaginitis. Kraurosis vulvae. Female castration. PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae.

PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (See Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Estrogens have been reported to increase the risk of endometrial carcinoma (See Boxed Warning). However, a recent large, case-controlled study indicated no increase in risk of breast cancer in postmenopausal women. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism, and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

For atrophic vaginitis

PREMARIN® (conjugated estrogens)

Vaginal Cream
0.625 mg/g



Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention, such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Pre-existing uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. It jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia or in young patients in whom bone growth is not yet complete. It concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

- Increased subfibrinogen retention.
- Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.
- Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T_4 by column, or T_4 by radioimmunoassay. Free T_3 resin uptake is decreased, reflecting the elevated TBG; free T_4 concentration is unaltered.
- Impaired glucose tolerance.
- Decreased pregnandiol excretion.
- Reduced response to meperidine.
- Reduced serum folate concentration.
- Increased serum triglyceride and phospholipid concentration.

As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

Long-term, continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. However, in a recent, large case-controlled study of postmenopausal women there was no increase in risk of breast cancer with use of conjugated estrogens.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyoma; vaginal candidiasis; change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

ACUTE OVERDOSEAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSEAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate-to-severe vasomotor symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 mg to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

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Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

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Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three- to six-month intervals.

Usual dosage range: 2 g to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer; an appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

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IMPACT OF THE SOLID WASTE CRISIS ON MEDICAL PRACTICES

RONALD COHEN, PH.D., MIDDLESEX*

The solid waste crisis has mandated that physicians in New Jersey counties arrange for the separate disposal of infectious waste. This has posed many unanticipated problems for the medical industry.

A fierce debate is waging over the environmental safety of garbage-burning incinerators as our landfills reach capacity and are closed one after the other.

The economic impact on the general public has made newspaper headlines throughout New Jersey. On August 6, 1987, the New Jersey Board of Public Utilities granted a 227 percent rate increase to the owners of the Edgeboro landfill. In addition, arrangements were made to restrict the use of the landfill to Middlesex County residents. The other counties using this landfill were ordered to develop a plan, subject to the approval of the New Jersey State Department of Environmental Protection, as to how they will get rid of their solid waste. The counties affected had to establish trash transfer stations by January 1, 1988. The garbage is dumped at the transfer stations, where it is loaded onto giant trucks and hauled to landfills in Pennsylvania. This led to another round of rate increases for disposal of our solid waste.

Until December 31, 1987, Morris County haulers were paying \$58.67 a ton to dump at the Edgeboro landfill in East Brunswick. As of January 1, 1988, they had to pay another 93 percent increase on top of the 227 percent granted only five months earlier. Somerset and Union Counties had similar second round increases in disposal costs.

This paper will discuss the details of the impacts on medical practice in Somerset County. However, it should be recognized that other counties, such as Hunterdon, Union, and Morris, face similar dilemmas and eventually, as more and more landfills close, the entire state may be impacted.

Somerset County signed a contract with the Empire landfill in Taylor, Pennsylvania. On January 1, 1988, Somerset County trash was redirected from the New Jersey landfill to the Pennsylvania landfill. The county was notified that the Pennsylvania Department of Environmental Resources has promulgated regulations which prohibit the disposal of pathological or infectious waste in any sanitary landfill in the state.

THE HEALTH INDUSTRY AND SOLID WASTE

Physicians, dentists, hospitals, veterinarians, public health clinics, and nursing homes discovered their garbage haulers would not pick up their waste. The collector/haulers for Somerset County were advised that an entire load with any infectious material would be turned away from the transfer station. Therefore, the physician or other generator would have to sepa-

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rate this material at the source or there would be no garbage collection.¹ Any load of waste with infectious material that arrived at the Pennsylvania landfill would be refused dumping rights and redirected to a landfill in West Virginia. The entire load would be redirected, not just the part with the infectious waste.

In Pennsylvania, infectious waste is identified as municipal waste which, prior to processing or disposal, is or may be contaminated by a disease-producing microorganism, or may pose a substantial present or potential hazard to human health when improperly processed, stored, transported, disposed, or otherwise managed.² This term includes, but is not limited to:

1. Wastes generated by hospitalized patients who have been isolated to protect others from communicable disease.
2. Cultures and stocks of etiological agents.
3. Waste blood and blood products.
4. Tissues, organs, body parts, blood and body fluids removed during surgery or autopsy, and other wastes generated by surgery or autopsy of septic cases or patients with infectious diseases.
5. Wastes that were in contact with pathogens in any type of laboratory work, including collection containers, culture tubes and dishes, slides, plates, and assemblies for diagnostic tests; and devices used to transfer, inoculate, and mix cultures.
6. Sharp instruments, including hypodermic needles, suture needles, disposable razors, syringes, pasteur pipettes, broken glass, and scalpel blades.
7. Wastes that were in contact with the blood of patients undergoing hemodialysis at hospitals or independent treatment centers.
8. Carcasses and body parts of animals exposed to zoonotic pathogens.
9. Animal bedding and other wastes that were in contact with diseased or laboratory research animals or their excretions, secretions, carcasses, or body parts.
10. Waste biologicals, e.g. vaccines produced by pharmaceutical companies for human or veterinary use.
11. Food and other products that are discarded because of contamination with etiological agents.
12. Etiologically contaminated equipment and equipment parts which are to be discarded.

Any Somerset County hospital, physician, or other generator of one or more items on this list was required to separate them from the general waste as of January 1, 1988. All health care professionals were notified that they had to contract with a firm that specializes in the removal and incineration of infectious waste.³ The firms that provided this service charged about \$40 to \$50 for the separate pickup. However, in contrast to the multiweek pickup service by the regular garbage haulers, the frequency of pickup of the infectious waste would depend on the volume generated. Somerset physicians were notified they would have only monthly service due to the low volume they generated.

It gradually became clear that the impact of the Pennsylvania regulations for landfill disposal would affect an even wider part of the medical service industry than originally was projected. Thus, on January 20, 1988, all school nurses in Somerset County were notified that they had to provide the Office of Solid Waste Management with certification of a separate contract with a medical waste hauler.⁴

Another idea came to the forefront: autoclave the infectious waste, render it harmless, and then put it out with the garbage, possibly in a separate bag marked that it had been sterilized by an autoclave by a physician. The Somerset County Solid Waste Program ruled this unacceptable. Pennsylvania certifies autoclaves while New Jersey does not. Until New Jersey establishes such a program and arranges an agreement for its acceptability with Pennsylvania, infectious waste will be refused, regardless of whether it has been autoclaved or not.

STATEWIDE IMPACT

The potential for future statewide impact of this crisis has been recognized by our legislators. On November 6, 1987, Senator McManimon prepared bill S-790, entitled, "An Act Establishing the New Jersey Medical Waste Study Commission and Making an Appropriation." The bill listed its purpose as "it is the public policy of this state to encourage the utilization of state-of-the-art waste management techniques in the disposal of medical waste in order to protect the environment."

This dilemma, in part, has encouraged some individuals to try to make solid waste disposal contracts with landfills in other states. Crossridge, Inc., owned by two New Jersey residents, currently is seeking permission from Governor Richard Celeste of Ohio to expand their Jefferson County landfill in eastern Ohio from 150 tons to 1,750 tons a day to accommodate New Jersey trash.⁵ This interest in Ohio as a landfill site may be due to lower costs for the disposal of wastes as compared to other states.⁶ The lower dumping charge may compensate for the increased hauling costs due to the greater distance required for hauling New Jersey trash.⁷

Ohio has established a committee to deal with the issue of interstate dumping of infectious waste and related issues.⁸ The committee concluded that there is no epidemiological or other evidence that public health is adversely affected by current infectious waste disposal practices. They had four recommendations:⁷

1. Careful consideration be given to the costs of further regulations since it is unlikely it will improve or protect the public health.
2. The categories designated by the Centers for Disease Control (CDC) as potentially infectious be adopted as the definition of infectious waste.⁸
3. Any regulations adopted in Ohio cover all generators of infectious medical waste, other than households.
4. The guidelines of the CDC regarding methods to render infectious waste noninfectious be considered adequate. The committee suggested use of steam sterilization, incineration, disposal of blood and body

fluids into the sanitary sewage system, and chemical disinfection/sterilization be included as an adequate alternative to render potentially infectious medical wastes non-infectious.⁸⁻¹⁰

The major difference between the two sets of recommendations is that the United States Environmental Protection Agency and CDC guidelines differ on the standards for handling communicable disease isolation wastes, contaminated laboratory wastes, surgery and autopsy wastes, dialysis unit wastes, and contaminated equipment.

NOSOCOMIAL INFECTIONS AND AIDS

There was only one report noted in the literature describing an infection due to the management of infectious waste.¹¹ The report describes an increase in nosocomial infections in a hospital in Illinois due to a chute-hydropulping waste disposal system. The general community and the waste handlers were not affected.¹¹ However, there are no standards for mandatory reporting and followup of injuries or occupational diseases acquired by workers who handle infectious waste at landfills or transfer stations. Therefore, we cannot conclude that the one case noted is the only one due to occupational exposure to infectious waste.

The prevention of nosocomial infections due to inadequate infectious waste control policies has been recognized by the Joint Commission for the Accreditation of Hospitals (JCAH) and the American Osteopathic Association (AOA). Routine inspections of hospitals by these accrediting agencies include a review of infectious waste policy.¹²

The emotional fear of AIDS and the extensive publicity during the summer of 1987 to the medical wastes floating onto the New Jersey beaches may have sensitized people to an unfounded fear of hazards associated with medical wastes. No cases of AIDS have been traced to swimming in polluted waters or to handling infectious waste by the haulers or workers.^{6,7}

The shifting pattern of disposal of New Jersey's solid waste from in-state to out-of-state disposal will subject the medical care establishment to restrictive legislation of the state in which the sanitary landfill is located. Perceived fears and resulting legislation will attempt to restrict dumping of any out-of-state waste that may have potential to pollute the environment. Prior to July 1, 1987, about 11 percent of the state's

waste was transported to out-of-state landfills. Since that date, Essex, Passaic, Morris, Somerset, Union, Hunterdon, and Bergen Counties have, or are developing, contracts with out-of-state sanitary landfills. When Bergen County ended its dumping at the Meadowlands on February 29, 1988, the out-of-state volume increased to 56 percent of the total New Jersey solid waste output.¹⁴

CONCLUSION

The solid waste crisis is having major potential impacts on the health care establishment. The need to develop adequate guidelines and definitions for the safe handling and disposal of medical wastes is being recognized in New Jersey.¹⁵ It is being brought to the forefront of new issues due to the solid waste disposal crisis and the increased interstate shipment of waste.¹³

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AN INTERVIEW WITH MOLLY JOEL COYE, M.D., PUBLIC HEALTH COMMISSIONER

LINDA JANET HOLMES, M.P.A., EAST ORANGE*

In an interview, the commissioner of health discusses key public health issues and briefly comments on future personal plans and the responsibility of women achievers to remain sensitive to barriers that many professional women still encounter.

At age 27, Molly Coye entered Johns Hopkins University School of Medicine. She received her medical degree and master's degree in public health in 1977, and was board certified in preventive medicine and occupational medicine in 1982. At the University of California-San Francisco, Dr. Coye completed her internship in the San Francisco General Hospital-Family Practice Program and her residency in the Department of Medicine as a Robert Wood Johnson Foundation clinical scholar. She served on the medical staff of the University of California-Berkeley Labor Occupational Health Program during her residency and, from 1979 to 1984, was chief of the Occupational Health Clinic at San Francisco General Hospital.

Prior to joining the New Jersey State Department of Health as deputy commissioner in 1986, Dr. Coye served as special advisor for health and environment in Governor Thomas Kean's Office of Policy and Planning. She developed programs addressing state health problems in three important areas: maternal and child health, the elderly, and occupational and environmental hazards.

Among many professional activities, Dr. Coye has been a leader in the American Public Health Association, as head of the Action Board from 1984 to 1985 and as a member of the Executive Board since 1985. She is affiliated with the New Jersey Public Health

Association, the American College of Preventive Medicine, the Society for Occupational and Environmental Health, and the National Association for Public Health Policy. Dr. Coye also is chairperson of the Advisory Committee to the Graduate Program in Public Health at UMDNJ—Robert Wood Johnson Medical School and Rutgers, the State University of New Jersey, and a clinical professor at the medical school.

Holmes: As commissioner of health, do you feel you have been able to keep your social change spirit alive?

Coye: First, very genuinely, Governor Kean has been tremendously supportive, when I was an adviser in the State House and when I've been commissioner. He basically has supported all of the significant public health goals that I've wanted to set forth in programs. He has made new funding available for several major areas. He has communicated to his staff in the State House expectations of the same degree of support. In my discussions with health commissioners in other states, I have a strong impression that I am very lucky; I have been granted both a great deal of latitude and specific support.

A second piece which is very important is that there is a staff in the Health Department that shares these

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Figure—Commissioner of Health Molly Joel Coye, M.D.

public health ideals in a specific and professional sense, and they are working to achieve social change in a broad sense. Of course, they have expertise in various areas. Frequently, my role is to organize support in terms of funding and getting regulations or legislation passed so that they can do what they might have wanted to do for a long time; that's very different from me thinking up all the ideas and then having to do it alone. If I did not have good staff in so many different areas, there would be a real limit to how much I could achieve.

Thirdly, I do not know if this is an accurate self-perception, but I think that attempting to do as much as I can in a nonconfrontational way is effective in increasing how much movement occurs in each direction.

Holmes: During your administration as commissioner, what are the priority areas that have been identified for public health?

Coye: In the area of uncompensated care—indigent care—we are the only state in the country that pays 100 cents on the dollar for the care of any person who does not have health insurance. Whether they are getting ambulatory care in a clinic or whether they are staying overnight as an inpatient, the patient's care is covered through this system called uncompensated care. There are only four or five other states that have a system that pays for health care for the indigent. These states only pay 60 to 70 percent of the cost, and there is much less of an incentive for hospitals to want to provide for indigent patients.

A study done by the Robert Wood Johnson Foundation last year compared access to care for people who do not have health insurance in New Jersey with other

indigent populations in the nation. This study showed that access to care, satisfaction with care, and perception of economic barriers on the part of minorities were significantly better by all measures in New Jersey. To me, that is very important validation that our system does work. While admittedly there still are significant problems even when the economic barriers to discrimination are removed, the social and political kinds of barriers often remain. This accomplishment in the area of uncompensated care is not mine by a long shot: the system was developed in 1979-1980, but it was in some danger of collapsing when I came in as commissioner. We passed new legislation in January 1988, which established a pool—a trust fund—to finance the care for the indigent. Again, this is very important to me and I feel very good about the accomplishment.

A second area of accomplishment is HealthStart. I think the idea of building into an entitlement program access to the full professionally recommended range of services by the American Academy of Pediatrics, the Institute of Medicine, and the American College of Obstetrics and Gynecology really is quite a path-breaking idea. So many of these programs in the past have been done through grants to small subsectors of the population. The idea that it is precisely the people who are poor who have the most need of the full range of recommended services and also are the least likely to get them, is something that really should be confronted directly. I hope HealthStart will be a model for the country.

The third priority area is AIDS. I think New Jersey has the toughest battle of any of the states that has a major AIDS burden because it is so predominantly

intravenous drug related. It has not proved to be easy, but it certainly is much more feasible to change the behavior of "gays" who are at risk than IV drug users. If you think about how many decades we have tried to fight the battle against drug abuse, you know how hard that is on its own terms. I think we have developed some innovative models such as the coupon program and ex-addict counsellors. Yet, we have not been able to go the distance. What really needs to be done is to have massive programs to get drug addicts out of addiction. Certainly, compared with other states, we have nothing of which to be ashamed. Nationally, only about 15 percent of heroin addicts are in contact with a system—receiving services at any time. We still are reaching only about 20 percent of the addicts. If we want to stop AIDS, we must find a way to massively reduce the number of people who are addicted. This is our biggest stumbling block.

The fourth priority area is in occupational health and safety and environmental health. In that area, we have a project called Project Teach where we are attempting to work directly with communities, unions, and other worker groups to try to resolve their concerns about health in the communities. In the past, a public health official would come to an auditorium and give a speech which might be designed primarily to give the public the message, "Don't worry, everything will be o.k." Other times, officials might have explained problems in very technical language which might have caused some people to be quite concerned or ill at ease. What we are trying to do is send in groups of health educators who actually can work with the local health officials and the community or worker groups to define what their concerns are, to figure out how to present the information in a way that will be helpful, and to make sure they understand the options that are available to them in trying to resolve a situation. We think this is a much better model of how public agencies should work with communities. This is true, not only for environmental health, but in other areas as well. It is less of a missionary or didactic kind of position and more of a participatory model.

Holmes: When you were in the Clinical Scholars Program at the Robert Wood Johnson Foundation, you spent some time thinking and writing about structuring conferences that actually involved participants who were the subjects of the research in the planning activity. Have you had an opportunity to use any aspects of that approach in the real world of public health?

Coye: I think that Teach and also the Teen Pregnancy Hearings were good examples of how that kind of approach can be very effective. For example, one of the things that the teens themselves expressed was support for alternative schools for pregnant women.

There has been a great deal of debate about whether these schools should be mainstream or separate schools. It is important to find out what people themselves think.

The fifth priority area for the department probably is more esoteric than you would want to get into for this article. It is reimbursement reform for the hospitals and is a rather complex issue.

Holmes: Where do you see yourself ten years from now?

Coye: I did not see myself here ten years ago, so I do not know how valuable that question is. I used to do a lot of international public health work, and at some point, I would like to return to it. I am very interested in international health and I did a lot of work in Latin America in particular, so that is a possibility.

I also find myself very much interested now in issues of access to health care, indigent care, and maternal and child health, which really is not my background. My background was occupational and environmental health, but I find it very satisfying to work on programs where you have such a rapid payoff as you do in maternal and child health. To me, indigent care seems to be one of the most pressing national problems, and it also is very satisfying to be able to feel that you are actually having an impact in that area. Therefore, I might continue to work in a policy or administrative job somewhere else.

Holmes: Could you comment on the importance of women willing to obtain positions of power. What psychological makeup is required to sustain those positions of power without fear?

Coye: There are all kinds of theories about what your family was supposed to have been like in order to produce children within certain molds. My family was tremendously supportive. They always encouraged me to be very experimental, to take on challenges that many other parents would not have allowed their children to do. They had a lot of confidence in me and were very interested in the work I did. Unlike some women who have struggled against tremendous adversities in order to reach positions of power, it simply did not occur to me that I should not do something or that there would be any question about whether I would be allowed to do something.

When I went to Hopkins and tried to start a women's group at the medical school the first year, the reaction of many women was "Why, we do not feel any discrimination against ourselves." But, intellectually, we must look at the patterns around us and recognize that many other people have a very rough time, and try to remove those barriers so that everyone has a shot at it, rather than just those people whose families gave them support.

AUTHOR INFORMATION

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A MISLEADING CERVICAL BRUIT IN CAROTID OCCLUSION

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The clinical usefulness of a carotid bruit is limited. In an asymptomatic patient with a carotid bruit, one cannot assume that carotid stenosis is present. Furthermore, asymptomatic carotid stenosis does not necessarily require treatment.

Auscultation of the neck, over the carotid artery at the angle of the jaw, is part of the routine physical examination. Noises in the areas overlying the carotid bulb allegedly provide useful information concerning the anatomical or pathological status of the carotid artery; murmurs heard from this area are considered to be among the best clinical evidence for the presence of atheromatous involvement of that artery.¹⁻⁵ When a loud and well-localized bruit was heard over the carotid region, Rennie and colleagues found that arteriography confirmed a stenosis in approximately 75 percent of patients.⁶ The genesis of such sounds is related to the disruption in laminar flow by irregularity of the vessel wall and by a reduction of the cross-sectional area. Absence of a bruit may indicate a normal or completely occluded vessel while disappearance of a bruit is consistent with the development of complete occlusion of the artery.^{1,7}

We observed and treated a patient who had a loud cervical systolic bruit and complete occlusion of the common carotid artery.

CASE REPORT

Six years prior to admission to the West Roxbury Veterans Administration Hospital, a 60-year-old man with a long history of hypertension presented with repeated episodes of transient monocular blindness

involving the left eye. An arteriogram revealed a high-grade stenosis of the left internal carotid artery just above the bifurcation and an endarterectomy was performed. He suffered a stroke in the distribution of the superior division of the left middle cerebral artery during the procedure and was left with a right hemiparesis and mild aphasia. The weakness improved over a period of several weeks and he remained stable. Subsequently, he again experienced loss of vision in the left eye lasting five minutes. There were no localizing hemispheric symptoms.

On admission to the West Roxbury Veterans Administration Hospital, vital signs were normal. Physical examination revealed a scar over the left carotid. There was a high-pitched, high-intensity (grade 3/4) non-radiating holosystolic bruit at the angle of the jaw on the left. No bruit was heard over the ipsilateral orbit or elsewhere and there were no cardiac murmurs. Neurologic examination of the patient revealed a mild right hemiparesis with hyperreflexia, mild anomia, and a right Babinski sign.

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Figure—Arteriogram showing the stump of the right vertebral artery (small arrow head); the stump of the left common carotid artery (large arrow head); and the left vertebral artery (middle-sized arrow head).

Routine CBC, SMA12, electrocardiogram, and chest x-ray were normal. Phonoangiography confirmed the presence of the murmur. A cerebral arteriogram revealed complete occlusion of the left common carotid artery near its origin and a widely patent right carotid artery. An ulcerated plaque was identified in the distal portion of the right common carotid artery. There was no cross-filling from the right carotid to the left anterior and middle cerebral arteries. Occlusion of the right vertebral artery also was noted (Figure).

DISCUSSION

Arterial murmurs are caused by changes in the vessel wall, abnormalities of the biophysical characteristics of blood, increase in flow, or a change in the pressure gradient across a stenosis or through a fistula.⁸ Bruits are transmitted along the artery in which they arise at approximately the speed at which the pulse wave travels.⁹ Stenosis from atherosclerosis is the most frequent pathologic cause of aorto-cervico-cranial murmurs. The common sites of atherosclerosis include the origins of the brachiocephalic artery; the left common carotid and the left subclavian arteries from the aortic arch; the vertebral artery origin; the bifurcation of the common carotid artery; and the region of the internal carotid siphon.¹⁰

Not all murmurs are pathologic, especially in young persons. Attempts have been made to characterize

murmurs in the neck using auscultatory criteria and, on this basis, to accurately determine the etiology.^{11,12} Excess pressure against the neck with the stethoscope may obliterate or accentuate the sounds.¹³

High-pitched, long duration bruits, as were found in our patient, usually are associated with stenosis. The tightest stenosis is said to produce a murmur which may continue into diastole. The bruits of stenotic vascular disease are difficult to separate from bruits which arise from benign physiologic or anatomic conditions. Although the criteria are not altogether clear, certain characteristics are reported to be helpful. Longer, lower-pitched murmurs which characteristically continue into diastole are associated with high velocity flow seen in anemia and high cardiac output, but not stenotic vascular disease.^{4,8} Venous hums are noises usually heard on the right side, low in the neck, and more apparent in the erect position when venous return is accelerated. They are prominent during diastole and can be obliterated by compressing the external jugular vein.

The point of origin, maximum intensity, and transmission characteristics are helpful in ascertaining the cause of a cervical murmur. A murmur over the eye may suggest ipsilateral internal carotid stenosis.^{2,8}

Further analysis of cervical bruits can be made with noninvasive techniques. Spectral phonoangiography has been shown to be highly reliable in predicting the carotid artery residual lumen in patients with carotid stenosis as compared to contrast angiograms and surgical specimens.¹⁴ However, such techniques have not been verified adequately for analysis of all patients presenting with bruits. Noninvasive techniques, when applied to bruits due to augmented circulation through patent vessels of the kind presented in our case, have an unknown degree of sensitivity and specificity.

Even if physiologic murmurs can be reliably excluded, the remaining pathologic murmurs do not all indicate internal carotid stenosis. Bruits heard over the branches of the external carotid arteries sometimes indicate disease in the internal carotid system, but in themselves do not represent markers for high stroke risk.¹¹ Fisher described several murmurs (augmentation bruits) reflecting disease outside the arteries being auscultated.¹⁵ A bruit may be heard in the carotid artery opposite the one occluded, presumably from the increased velocity with which blood must flow in order to supply its normal territory as well as a portion of the other hemisphere. When the internal carotid artery above is entirely occluded, a murmur may be heard in the area of the bifurcation of the common carotid artery. This is thought to be related to a relative narrowing at the origin of the external carotid artery. Finally, a vertebral bruit may be heard from the supraclavicular fossa to the mastoid region posterior to the usual location of the carotid artery. This bruit may be misinterpreted as originating in the carotid, but has been found in patients with bilateral carotid occlusions, subclavian steal, and hemangioma of the brain stem.^{2,15}

COMMENT

Our patient presented with a transient ischemic event in the distribution of the left internal carotid

artery. Examination revealed a bruit whose pitch, duration, and amplitude seemed indicative of internal carotid artery stenosis. The arteriogram, however, showed no flow of blood through either the internal or external carotid system on the left. In addition, there was occlusion of the right vertebral artery. The noise heard apparently represented an augmentation bruit of the left vertebral artery which followed the occlusions.

Because of the difficulty in separating physiologic and nonlocalizing bruits from those which are indicative of stenosis, the clinical usefulness of a cervical bruit is limited. When transient neurological deficits occur with or without a bruit, it is important to visualize the carotid system to diagnose stenosis or ulcerated plaque. A bruit alone, indeed, may not always indicate an underlying vascular lesion in the artery, as in this case.

Moreover, asymptomatic carotid bruits in which stenosis is proved at angiography or suggested by phonoangiography do not necessarily require treatment. The natural history of untreated carotid stenosis is not known.¹⁶⁻¹⁸ Even in the presumably high-risk patients who undergo major cardiovascular surgery with known carotid stenosis, the presence of an asymptomatic carotid stenosis does not necessarily predispose them to perioperative stroke.¹⁹

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STATE OF THE ART: CURRENT STATUS OF BREAST IMAGING

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One of the major indications for mammographic imaging is for surveillance of breast parenchyma for malignant changes which are clinically occult. This article deals with the status of mammography as a screening tool, as well as its other applications.

Carcinoma of the breast maintains its prevalence as the most common malignancy affecting women.¹ Early detection of this clinical entity has become a mandate for today's medical practitioners. Multiple statistical studies have been designed to elucidate the value of early detection programs for breast cancer.

THE VALUE OF EARLY DETECTION

During the 1960s, the Health Insurance Plan of New York conducted a prospective study in which they compared one population of women who underwent annual mammographic examinations and breast palpation with a second control population who only underwent routine health care. The study concluded that there was a significant decrease in mortality of the study group versus the control group.²

In the 1970s, the Breast Cancer Detection Project was carried out as a national multicenter study in which over a quarter of a million women were evaluated with clinical and x-ray examinations.³ This study revealed that x-ray mammography uncovered a statistically significant number of breast carcinomas which were not evident on clinical examination.

IMPORTANCE OF LOW-DOSE MAMMOGRAPHY

In the 1960s and early 1970s, relatively high radiation doses were delivered to the breasts during mammography. The doses were on the order of 1 to 2 rads per exposure. Since at least two radiographic projec-

tions to each breast were performed, this resulted in an approximate total exposure of 2 to 4 rads per breast. With this information, controversy arose regarding the safety of mammography for early detection of breast malignancy, since it was theorized that high-dose mammography could itself be a carcinogen.

Since 1976, the Food and Drug Administration (FDA) has been measuring mammographic radiation exposures at multiple clinical installations nationwide.⁴ In the past ten years, there has been a substantial decrease, on the order of 50 percent, in total dosage to the breasts. Many technical factors are responsible for the current state-of-the-art, low-dose mammographic systems including technological advances, improved film-screen combinations, phototiming devices, and compression equipment.

Modern mammographic units yield doses on the range of 0.05 to 0.5 rads per exposure. These relatively low radiation doses imply that there is a good risk-benefit ratio in the use of x-ray mammography as a screening examination.

GUIDELINES FOR SCREENING MAMMOGRAPHY

The American Cancer Society in conjunction with the American College of Radiology and other pro-

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professional organizations recommend the following guidelines in the implementation of mammography for breast cancer screening of asymptomatic women: 1. a baseline study at age 35; 2. women who are between the age of 40 and 49 should have a mammogram every one to two years; and, 3. over the age of 50, annual mammographic examinations are advised.

THE ROLE OF THE CLINICIAN

Referring physicians must be aware of the capabilities of the imaging facility in order to provide the optimal screening examination.⁴ Primarily, it is imperative that the radiologist and technical staff receive adequate training in the acquisition and interpretation of mammographic images. Additionally, one should ascertain that the facility is utilizing dedicated low-dose mammography technology which generates top-quality diagnostic images. The equipment should undergo periodic assessment by a health physicist, and it should meet present low-dosage requirements.

The referring clinician plays a key role as an educator and should provide factual information to patients. Outlining the mammographic procedure with patients prior to the actual study can be efficacious in allaying anxieties and dispelling any unrealistic notions.

METHODOLOGY

During the examination, the patient stands; each breast is compressed by a mechanical contrivance in the horizontal direction for the craniocaudal projections and in a semi-vertical fashion for the mediolateral oblique projections. (The radiologist may elect to add other views to the study.) During the compression of the breast, there may be discoloration and some discomfort of the breast. It is quite important to attain optimal compression since this "spreads out" the breast parenchyma allowing better visualization of any underlying breast lesions. Adequate compression also results in a lower absorbed dose of radiation to the breast. During the few seconds of the compression, the x-ray technologist stands behind a shield and makes an exposure; the compression on the breast is released immediately after exposure. The patient should be reassured that no major untoward effect will be rendered by mechanical compression of her breast. Any discomfort to the breast in the postmammographic period will be shortlived, but may be treated symptomatically with aspirin or acetaminophen. Maximal breast tenderness usually occurs just prior to the onset of menses; the scheduling of mammography can be made for the time following the cessation of the menstrual period.

LIMITATIONS AND ADVANTAGES

Although mammography is highly effective in early detection, it should be realized that this modality has limitations. A negative mammogram cannot completely exclude the presence of a carcinoma. Therefore, an unrevealing mammogram should not negate the indication for biopsy of a clinically detected abnormality. Mammography has a good sensitivity in regards to detection of lesions, however, its specificity with regards to diagnosis is relatively low. It should be stated

clearly that the only true diagnostic modality for breast lesions is histological evaluation of aspiration and biopsy specimens.

The radiologist plays a pivotal part in ascertaining the need for a breast biopsy. There are a finite number of benign entities recognized mammographically and they have been dubbed "leave alone" lesions.⁵ This category includes benign calcifications, dermal lesions, lipomas, and intramammary lymph nodes. Other entities may be indeterminate and are placed in a "probably benign" category. In this case, the radiologist defers the biopsy and elects to follow the lesion over a certain interval for further characterization.

NONMAMMOGRAPHIC BREAST IMAGING

Presently, other imaging modalities have not proved to be effective in early detection of breast cancer.⁶ Ultrasound has proved useful in cyst/solid differentiation of lesions and also as a guide for cyst aspiration. Ultrasound is used only after detection of a lesion by mammography and/or palpation.

Computed tomography (CT) may be used in complicated cases where mammography for needle localization of a lesion prior to surgical biopsy has been ineffective. CT is especially helpful in identifying lesions close to the chest wall.

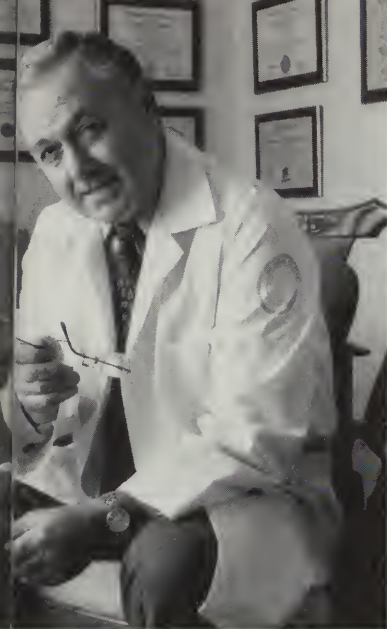
The other modalities available to the practicing radiologist presently are not helpful in detection or diagnosis of breast cancer and are considered experimental at best. Thermography has been shown to have very high false-positive and false-negative rates. Diaphanography or transillumination light scanning has poor sensitivity and specificity. Magnetic resonance imaging (MRI) at this time is an investigative technique. Radiologists are on the upslope of the learning curve with regard to MRI. So far, present MRI technology does not appear to offer any primary or adjunctive uses in breast imaging.

CONCLUSION

Guidelines have been determined for the use of mammography in screening of the female population for occult early breast carcinomas. Mammography also is recommended for: evaluation of clinically detected lesions; detection of synchronous clinically occult tumors in the ipsilateral or contralateral breast; and presence a benign or "probably benign" lesion. Mammography is implemented in needle localization of nonpalpable lesions prior to surgical biopsy.

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MEDICAL HISTORY: DEFIBRILLATION FLAMBÉ

VICTOR PARSONNET, M.D., NEWARK*

The author's laboratory experience notes an exciting event in medical history; and the author reports the success of his work.

One day in 1962, I made history and didn't know it—until 26 years later. After temporary transvenous pacing was first initiated by Furman and his associates, we began to use a transvenous wire for temporary pacing in every patient who was being prepared for subsequent transthoracic implantation of a permanent pacemaker. We used one that had been adapted from a model loaned to us by Dr. Charles Kossman, with two platinum-iridium electrodes 1 cm apart at the tip of the lead. By that time, we had completed several studies on transthoracic AC and DC defibrillation, and already had described an inhospital "Dr. Pacemaker" emergency call system for sudden death;¹ it was the predecessor of the present-day cardiopulmonary resuscitation programs, now called "Code 1," "Code Blue," or some such poorly disguised bell over the hospital paging system.

With my research associates, Drs. George Myers, Gerhard Lewin, and I. Richard Zucker, I was studying transvenous pacing in the dog laboratory. Based upon our prior experience, it seemed an obvious next step to try to defibrillate the heart transvenously. We knew how much energy was required, approximately 40 joules, and took some time to find a way to deliver that much energy with a proper waveshape. Eventually, we settled on a Medtronic laboratory pulse generator that drove a MacIntosh audio amplifier someone had found in his storeroom.

After anesthetizing a dog, I introduced the lead into the right ventricle and induced ventricular fibrillation

(VF) with a long burst of AC. After 15 seconds of fibrillation, we fired the MacIntosh amplifier across the bipolar lead. There was a loud, sharp snap, smoke everywhere, and a smell of ozone and burnt flesh. The heart was not defibrillated, and by the time we had recovered our equilibrium, the dog was lost.

The lead was disrupted near the proximal electrode as if there had been a small explosion, presumably because the current far exceeded the capacity of the lead. The right ventricular surface of the interventricular septum had a burn 2 cm in diameter.

We concluded at that time that transvenous defibrillation was not possible. We now conclude that we were the first to perform (unsuccessful) transvenous defibrillation, and the first to perform endocardial ablation of whatever it was we had cooked.

Note: We have just learned how to do it successfully.²

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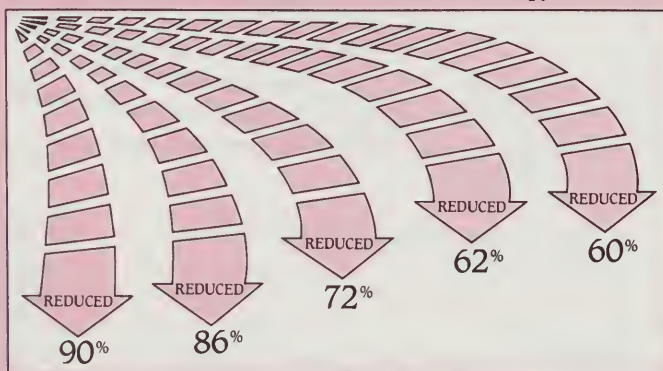


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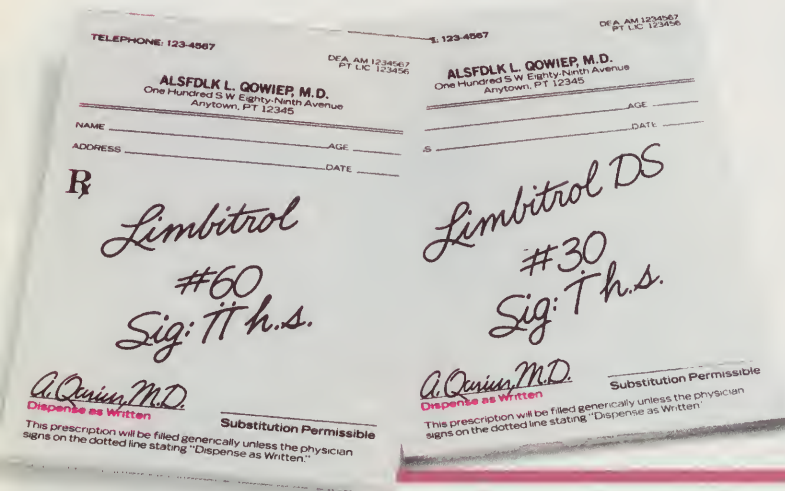
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Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, nervousness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

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Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

How Supplied: Double strength (DS) Tablets, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and Tablets, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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CLINICAL NOTE: CHEMICAL DEPENDENCY AND THE FAMILY

JOHN J. VERDON, JR., M.D., TINTON FALLS*

Alcoholism and chemical dependency are escalating diseases. Collaboration with the family, Alcoholics Anonymous, Narcotics Anonymous, and treatment centers is imperative. The physician should remain actively engaged with the patient and the family throughout the course of treatment.

The approach to the disease of chemical dependency must be simple. At the time of the initial evaluation, a number of factors must be considered. Of paramount importance, however, is the general medical condition of the presenting patient and the need for management of withdrawal in a controlled, therapeutic setting. Significant factors that dictate admission to such a center include, but are not limited to: the presence of tremors of the hands and, in particular, of the tongue; daily intake of large quantities of alcohol (160 gm/16 oz/day); and the history of seizures or episodes of delirium tremens during previous attempts to achieve abstinence. In general, the use of alcohol combined with other hypnotic agents, or the repetitive use of hypnotic agents in a daily dose estimated to be greater than the equivalent of 400 mg of pentobarbital per day, indicate the urgency of hospitalization for withdrawal management. Although many patients do not suffer major symptoms of abstinence, their compulsion to use is such that a protective therapeutic environment is essential to begin the recovery process. Confrontation can be achieved effectively when the patient feels most vulnerable, while at the depth of his despair, and is most amenable to the concept of "surrender."

Those patients who appear on an urgent basis to the emergency room of a general hospital often are ad-

mitted at that point in time for safe withdrawal from their mood-altering substances including alcohol and other agents. The vast majority of such patients employ more than one substance. Age seems to be a consistent predictor of the substances the identified patient indicates as the drug of choice. The most common substances abused by persons seen in clinical practice today are alcohol, cocaine, opiates, and marijuana. It is striking that the majority of patients do not believe they have "lost control" over all these agents, but are of the opinion that only a specific substance is presenting problems at one point in time. As indicated, most of the individuals require a medical facility for the treatment of the abstinence syndrome. Unfortunately when this process is completed, most patients wish to return rapidly to the community and reject the notion that they must embark upon recovery in a controlled therapeutic environment.

If the patient contacts the practitioner in his office, an evaluation should be conducted as soon as possible. After performing a careful psychiatric examination and overall health assessment, a working diagnosis is

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formulated. If the patient does not appear to be afflicted with complicating psychiatric illness, he can begin recovery with the assistance of an appropriate self-help group. Experience advises that additional appointments be scheduled with the physician to monitor the patient's progress. It is imperative that family members be evaluated by the practitioner so that an accurate assessment can be completed and that those codependents can be directed for treatment of their own issues. Based upon the response of both patient and family, the treatment plan may be modified as indicated.

If psychiatric examination reveals evidence of emotional illness, an attempt to engage the patient in a supportive psychotherapeutic process is appropriate. Concomitantly, patient and family are referred to the appropriate self-help group. Neuroleptic medications may be indicated in treatment of "double-trouble" patients, e.g. lithium for bipolar patients; imipramine for panic disorder. The combination of major depressive illness and chemical dependency warrants hospitalization in a psychiatric facility so that an attack can begin on both problems. If vegetative signs of depression persist after safe withdrawal from the offending chemical substances, one must seriously consider the introduction of antidepressant medication. However, dysphoria is so ubiquitous in early sobriety one is hesitant to use pharmacological approaches initially. Adequate rest, nutrition, and vitamin supplementation (in particular, folic acid and thiamine) are indicated. "Recovery sensitive" psychotherapy often is extremely beneficial. However, it must be made clear between the therapist and the patient that the recovery process be an uncomplicated one. The focus lies not on analyzing the reasons for "the use of the mood-altering substances" but in dealing with those barriers to recovery.

***After performing a careful
psychiatric examination
and overall health
assessment, a working
diagnosis is formulated.***

Residential as well as outpatient treatment centers prove most helpful in aiding the patient to confront his denial. In addition, those centers help bring the family into treatment. Frequently, patients and codependents who seek office therapy are highly resistant to other help. In determining the necessity of residential treatment at the onset of recovery, the assessment of the intensity of denial is a key factor. Those who are "reluctant to recover" are most in need of starting recovery in a setting removed from the stresses of the workday life. It is imperative that the family be involved in treatment while the patient is in residence. Those programs that mandate this, and offer a quality family program attached to the facility,

warrant high marks. Although it is ideal for the patient to be treated within easy reach of his home community, the major issues that must be dealt with are the denial of his own illness and the need for continuing treatment on a "one day at a time" basis after discharge. Aftercare/alumni groups do prove beneficial.

However, the task of all "professional treatment" is to deal with the patient's resistance; entrance into the 12-step recovery programs of Narcotics Anonymous and Alcoholics Anonymous as well as family treatment in Al-Anon and Nar-Anon are important. Issues dealing with both psychodynamic formulations and parental alcoholism (with the myriad problems which it fosters for the adult child) must await intensive treatment of the primary chemical dependency and a commitment to sobriety. While it is true that many patients with adult-child issues and other significant psychodynamic factors may relapse if these matters are not addressed, recovery must be firmly established, confronting the reality of today before the past is probed. The process of exploratory psychotherapy is hardly simple and runs counter to the imperative guideline of recovery, i.e. keep it simple.

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Brief Summary. Consult the package insert for prescribing information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients, at a reduced dosage of 150 mg b.i.d. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H₂-receptor antagonists.

Precautions: General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy with nizatidine.

Drug Interactions—No interactions have been observed between Axid and theophylline, chlorazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice; although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement

compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use—Safety and effectiveness in children have not been established. **Use in Elderly Patients**—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to

determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT (AST), SGPT (ALT), or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H₂-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD₅₀ values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

Axid[®] (nizatidine, Lilly)



Eli Lilly and Company
Indianapolis, Indiana
46285

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COMMENTARY: COUNTY JOURNAL ANNIVERSARY

MARY G. ROEBLING, TRENTON*

The author writes about her wishes that scientific and lay publications help the public better understand the price young people pay to become physicians and the price doctors pay to render service.

I believe I can say that most physicians are touched by the divine. I say this strictly as a lay person, not as a member of the medical community in any way, but as an individual who has relatives who are physicians, and who has had many years of experience with doctors. Indeed, doctors have saved my life several times.

Try as I might, I can think of no other profession whose members give so much of themselves as a normal part of their day and who make so many critical contributions to the well-being of individuals and of society—again, as a normal part of their day.

Increasingly in recent years, it has become fashionable to attack the medical profession generally, and physicians in particular. The number of so-called malpractice suits has skyrocketed so that the cost of malpractice insurance is almost out of sight for the average doctor.

In this regard, one problem with the American people—many of them—is they do not realize just how incredibly fortunate they are:

1. To live in a nation which not only permits but encourages free enterprise in medicine and which, at the same time, maintains strict controls on its practice;

2. To benefit from a medical profession with the world's highest standards in training, research, and practice;

3. To benefit from a system providing an adequate number of doctors, in general terms, for the entire population; and

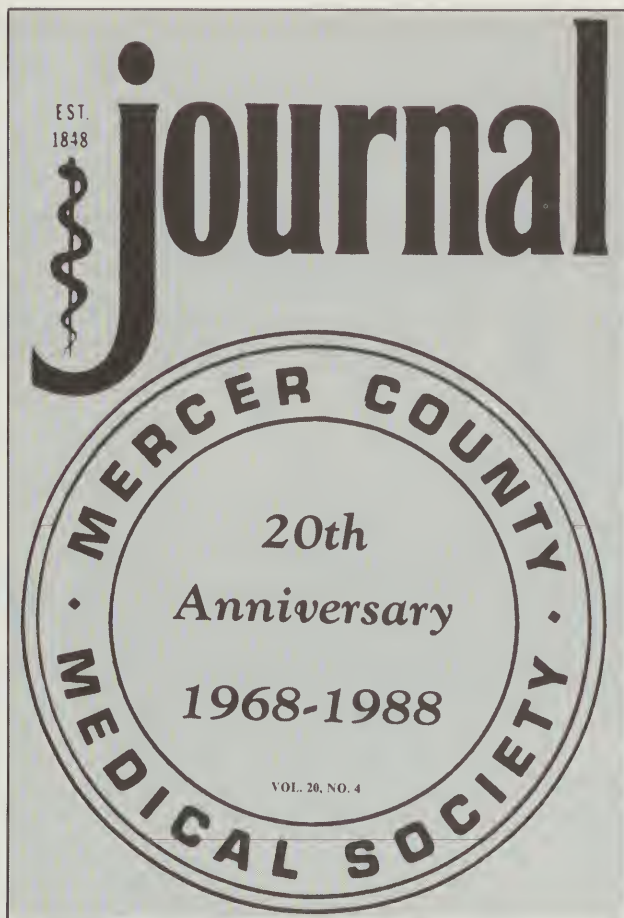
4. To benefit from a system providing service and research in every known biomedical discipline and subspecialty and in every specialty and subspecialty.

If the reader should have any questions about this, he or she should look at the statistics on the thousands of foreign medical students trying to get into American schools every year, and at the thousands of trained foreign physicians trying to move into the United States to practice here.

Part of the strength and versatility of the American medical system comes from its hundreds and hundreds of county medical groups, like the Mercer County Medical Society. And one of the reasons is medical communications. Scientists all over the world are carrying out research on thousands of medical projects crucial to our health and to the health of our children and our grandchildren. The result? Well, the National Library of Medicine in Washington estimates that the world medical literature is growing at a rate of probably ten million pages every year. That's nearly 300 books, of a thousand pages each, every day.

Take just one-tenth of that, or about three books a day. Do you, or does your physician or any physician

*This essay was published in the 20th anniversary edition of the journal of the Mercer County Medical Society.



the reader may know, have time to read even one book a day? Certainly not. In their dedication to their pa-

tients, the doctors are on the run from morning until night, and into the night.

So while it's impossible for the physician to keep up with every new advance in medicine, it is very important for them to have regular opportunities to talk with their colleagues. Medical societies provide this opportunity. More, associations like the one in Mercer County are in a position to invite speakers on subjects such as new pharmaceuticals, new treatment procedures, and new surgical techniques.

(And, by the way, it is obvious that any physician not a member of his county society is missing an opportunity to provide better service to his patients.)

It is also in the field of communications, as in so many other fields, that Americans are blessed. We have the freedom to communicate, without restraint, on any subject. This has made for better lawyers, better engineers, and, most assuredly, better physicians. Communications are part of the total picture of America's medical muscle. The Mercer County journal is an example. I cannot understand a third of the big words in the articles, but the physicians can, and my doctor friends and relatives tell me this journal is doing an excellent job for Mercer County medicine.

That is as it should be. I would hope, however, that this publication—and scores of other scientific and lay publications—can help the public better understand the price that young people pay in sweat and headaches (and dollars) to become physicians, and the price that doctors, of any age, pay in stress and fatigue to render adequate service to the men, women, and children of this nation.

Americans are blessed from their toenails to their scalps with the finest physicians in the world, but they are not aware of it and they need to be told.

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INDICATIONS: THEO-DUR is indicated for relief and/or prevention of symptoms of asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

CONTRAINDICATIONS: THEO-DUR is contraindicated in individuals who have shown hypersensitivity to theophylline or any of the tablet components.

WARNINGS: Status asthmaticus should be considered a medical emergency and is defined as that degree of bronchospasm which is not rapidly responsive to usual doses of conventional bronchodilators. Optimal therapy for such patients frequently requires both *additional medication*, parenterally administered, and *close monitoring*, preferably in an intensive care setting.

Although increasing the dose of theophylline may bring about relief, such treatment may be associated with toxicity. The likelihood of such toxicity developing increases significantly when the serum theophylline concentration exceeds 20 mcg/ml. Therefore, determination of serum theophylline levels is recommended to assure maximal benefit without excessive risk.

Serum levels above 20 mcg/ml are rarely found after appropriate administration of recommended doses. However, in individuals in whom theophylline plasma clearance is reduced for any reason, even conventional doses may result in increased serum levels and potential toxicity. Reduced theophylline clearance has been documented in the following readily identifiable groups: 1) patients with impaired renal or liver function; 2) patients over 55 years of age, particularly males and those with chronic lung disease; 3) those with cardiac failure from any cause; 4) neonates; and 5) those patients taking certain drugs (macrolide antibiotics and cimetidine). Decreased clearance of theophylline may be associated with either influenza immunization or active infection with influenza.

Reduction of dosage and laboratory monitoring is especially appropriate in the above individuals. Less serious signs of theophylline toxicity (i.e. nausea and restlessness) may occur frequently when initiating therapy, but are usually transient, when such signs are persistent during maintenance therapy, they are often associated with serum concentrations above 20 mcg/ml. Unfortunately, however, serious side effects such as ventricular arrhythmias, convulsions or even death may appear as the first sign of toxicity without any previous warning. Stated differently: *serious toxicity is not reliably preceded by less severe side effects.*

Many patients who require theophylline may exhibit tachycardia due to their underlying disease process so that the cause/effect relationship to elevated serum theophylline concentrations may not be appreciated.

Theophylline products may cause dysrhythmia and/or worsen pre-existing arrhythmias and any significant change in rate and/or rhythm warrants monitoring and further investigation.

The occurrence of arrhythmias and sudden death (with histological evidence of necrosis of the myocardium) has been recorded in laboratory animals (minipigs, rodents and dogs) when theophylline and beta agonists were administered concomitantly, although not when either was administered alone. The significance of these findings when applied to human usage is currently unknown.

PRECAUTIONS: THEO-DUR TABLETS SHOULD NOT BE CHEWED OR CRUSHED.

General: Theophylline half-life is shorter in smokers than in non-smokers. Therefore, smokers may require larger or more frequent doses. Morphine and curare should be used with caution in patients with airway obstruction as they may suppress respiration and stimulate histamine release. Alternative drugs should be used when possible. Theophylline should not be administered concurrently with other xanthine medications. Use with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, in the elderly (especially males) and in neonates. In particular, great caution should be used in neonates with theophylline to patients with congestive heart failure. Frequently, such patients have markedly prolonged theophylline serum levels with theophylline persisting in serum for long periods following discontinuation of the drug. Individuals who are rapid metabolizers of theophylline, such as the young, smokers, and some non-smoking adults, may not be suitable candidates for once-daily dosing. These individuals will generally need to be dosed at 12 hour or sometimes 8 hour intervals. Such patients may exhibit symptoms of bronchospasm near the end of a dosing interval, or may have wider peak-to-trough differences than desired.

Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to the G.I. tract although gastrointestinal symptoms are more commonly centrally mediated and associated with serum drug concentrations over 20 mcg/ml.

Information for Patients: The physician should reinforce the importance of taking only the prescribed dose and time interval between doses. THEO-DUR tablets should not be chewed or crushed. When dosing THEO-DUR on a once daily (q24h) basis, tablets should be taken whole and not split. As with any controlled-release theophylline product, the patient should alert the physician if symptoms occur repeatedly, especially near the end of the dosing interval.

DRUG INTERACTIONS: Drug-Drug: Toxic synergism with ephedrine has been documented and may occur with some other sympathomimetic bronchodilators. In addition, the following drug interactions have been demonstrated:

Drug	Effect
Theophylline with lithium carbonate	Increased excretion of lithium carbonate
Theophylline with propranolol	Antagonism of propranolol effect
Theophylline with cimetidine	Increased theophylline blood levels
Theophylline with troleandomycin, erythromycin	Increased theophylline blood levels

Drug-Food: THEO-DUR 100 mg Sustained Action Tablets have not been adequately studied to determine whether their bioavailability is altered when given with food. Available data suggest that drug administration at the time of food ingestion may influence the absorption characteristics of theophylline controlled-release products resulting in serum values different from those found after administration in the fasting state.

A drug-food effect, if any, would likely have its greatest clinical significance when high theophylline serum levels are being maintained and/or when large single doses (greater than 13 mg/kg or 900 mg) of a controlled-release theophylline product are given.

THEO-DUR (200, 300, and 450 mg) Sustained Action Tablets: The rate and extent of absorption of theophylline from THEO-DUR 200 mg, 300 mg, and 450 mg tablets when administered fasting or immediately after a moderately high fat content breakfast is similar.

Drug-Laboratory Test Interactions: When plasma levels of theophylline are measured by spectrophotometric methods, coffee, tea, cola beverages, chocolate, and acetaminophen contribute falsely high values.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic potential, mutagenic potential, or the effect on fertility of xanthine compounds.

Pregnancy: Category C—Animal reproduction studies have not been conducted with theophylline. It is not known whether theophylline can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Xanthines should be given to a pregnant woman only if clearly needed.

Nursing Mothers: It has been reported that theophylline distributes readily into breast milk and may cause adverse effects in the infant. Caution must be used if prescribing xanthine to a mother who is nursing, taking into account the risk-benefit of this therapy.

Pediatric Use: Safety and effectiveness of THEO-DUR administered:

1. Every 24 hours in children under 12 years of age, have not been established
2. Every 12 hours in children under 6 years of age, have not been established.

ADVERSE REACTIONS: The most consistent adverse reactions are usually due to overdose and are:

1. **Gastrointestinal:** nausea, vomiting, epigastric pain, hemeatemesis, diarrhea.
2. **Central nervous system:** headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions.
3. **Cardiovascular:** palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias.

4. **Respiratory:** tachypnea

5. **Renal:** albuminuria, increased excretion of renal tubular and red blood cells, potentiation of diuresis.

6. **Other:** rash, hyperglycemia and inappropriate ADH syndrome.

OVERDOSEAGE: Management: If potential oral overdose is established and seizure has not occurred:

- A. Induce vomiting.
 - B. Administer a cathartic (this is particularly important if sustained-release preparations have been taken).
 - C. Administer activated charcoal.
- If patient is having a seizure:
- A. Establish an airway.
 - B. Administer oxygen.
 - C. Treat the seizure with intravenous diazepam, 0.1 to 0.3 mg/kg up to 10 mg.
 - D. Monitor vital signs, maintain blood pressure and provide adequate hydration.

Post Seizure Care:

- A. Maintain airway and oxygenation.
- B. If a result of oral medication, follow above recommendations to prevent absorption of the drug, but intubation and lavage will have to be performed instead of inducing emesis, and the cathartic and charcoal will need to be introduced via a large bore gastric lavage tube.
- C. Continue to provide full supportive care and adequate hydration while waiting for drug to be metabolized. In general, the drug is metabolized sufficiently rapid so as not to warrant consideration of dialysis, however, if serum levels exceed 50 mcg/ml charcoal hemoperfusion may be indicated.

CAUTION: Federal law prohibits dispensing without prescription. For full prescribing information, see package insert. Revised 6/87

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At ceremonies held on April 29, 1988, during the Annual Meeting of the Medical Society of New Jersey, the following physicians received MSNJ's Golden Merit Award indicating they held the degree of Doctor of Medicine for 50 years.

Atlantic County

Martin Green, M.D. Jefferson 1938
 Jay Eli Mishler, M.D. Edinburgh 1938
 Abraham Paul, M.D. Temple 1938

Bergen County

Alfred A. Alessi, M.D. New York University 1938
 Louis V. Angioletti, Sr., M.D. New York Medical 1938
 James S. Brescia, M.D. Vermont 1938
 Louis DeLuca, M.D. New York Medical 1938
 Gustav Friedmann, M.D. New York University 1938
 Vincent W. Giudice, M.D. Hahnemann 1938
 Marion McIlveen, M.D. Woman's Medical 1938
 Herbert G. Miller, M.D. Long Island 1938
 Roy Pollack, M.D. Johns Hopkins 1938
 Everett C. Ravits, M.D. Minnesota 1938
 Bertha P. Rodger, M.D. Boston 1938
 Frank Dean Roylance, M.D. Columbia 1938
 Leo P. Schultz, M.D. Georgetown 1938
 Robert E. Verdon, M.D. St. Louis 1938

Camden County

Mark Brown, M.D. Dalhousie 1938
 Charles F. Deaterly, M.D. Pennsylvania 1938
 James R. Eynon, M.D. Hahnemann 1938
 George Vernon Judson, Jr., M.D. Jefferson 1938
 Vincent P. Mahoney, M.D. Pittsburgh 1938

Henry S. Price, Jr., M.D. Jefferson 1938
 Leland M. Stetser, M.D. Hahnemann 1938

Cape May County

Samuel John Mazzotta, M.D. Syracuse 1938

Cumberland County

Richard Kerdasha, M.D. Pennsylvania 1938

Essex County

Samuel B. Balis, M.D. Louisville 1938
 Joseph D. Barbella, M.D. Hahnemann 1938
 Francis T. Christoph, M.D. Georgetown 1938
 Pasquale R. Dante, M.D. Hahneman 1938
 Harry Diener, M.D. Vienna 1938
 David H. Dreizin, M.D. ... New York University 1938
 Edmond Edelson, M.D. Louisiana 1938
 Samuel N. Feinsod, M.D. . Cincinnati Eclectic 1938
 Albert L. Gaydos, M.D. St. Louis 1938
 Vincent J. Giardina, M.D. .. New York Medical 1938
 Leonard Gilman, M.D. Tufts 1938
 Kenneth Goodman, M.D. Columbia 1938
 Angelo B. Iannone, M.D. Jefferson 1938
 Andrew Kallos, M.D. Paris VI 1938
 Harry A. Kaplan, M.D. Minnesota 1938
 Roman Kawalek, M.D. Vienna 1938
 Carl Knitzer, M.D. Arkansas 1938
 James Koch, M.D. Bologna 1938
 Murray Levin, M.D. Glasgow 1938

John F. Long, M.D. New York Medical 1938
 Melvin Lustig, M.D. Jefferson 1938
 Charles L. O'Neill, Jr., M.D. Georgetown 1938
 Samuel L. Pollock, M.D. Edinburgh 1938
 Irving M. Riffin, M.D. New York University 1938
 Mortimer L. Schwartz, M.D.
 Cincinnati Eclectic 1938
 Irving Shapiro, M.D. George Washington 1938
 Ralph Tuly, M.D. Long Island 1938
 Arthur C. Tutela, M.D. Loyola 1938
 Robert J. Van Amberg, M.D. Cornell 1938
 Ralph N. Villanova, M.D. Perugia 1938
 David Wiener, M.D. (deceased) Indiana 1938
 Henry J. Wujack, M.D. Syracuse 1938

Hudson County

Charles John Aria, M.D.
 Cincinnati Eclectic 1938
 Anthony John Balsamo, M.D. Hahnemann 1938
 Henry Domenick Chieffo, M.D. Georgetown 1938
 Gerald E. De Sevo, M.D. Georgetown 1938
 Leo Horowitz, M.D. Dalhousie 1938
 Irving Marshall, M.D. Temple 1938
 Armand Mario Milanesi, M.D. Loyola 1938
 Charles Louis Quaglieri, M.D. Naples 1938
 Harry Morton Schneider, M.D. Cincinnati 1938

Hunterdon County

Charles Buckman Katzenbach, M.D.
 Columbia, 1938

Mercer County

Perry Albert, M.D. Jefferson 1938
 John Daniel Barlow, M.D. Georgetown 1938
 Ivan Frank Bird, M.D. Hahnemann 1938
 W. Laurence Bonnet, M.D. Hahnemann 1938
 Norman William Garwood, M.D. . Hahnemann 1938
 Harold K. Harvey, M.D. Vienna 1938
 John A. Kinzel, M.D. Pennsylvania 1938
 Joseph Jay Kline, M.D. Jefferson 1938
 William G. Rose, M.D. Temple 1938

Middlesex County

Alfred J. Barbano, M.D. Temple 1938
 Maria G. Koroljow, M.D. Odessa 1938
 Bernard M. Kramer, M.D. Rush 1938
 Samuel C. Lavine, M.D. London 1938
 John Y. Ma, M.D. Shanghai 1938
 Gabriel Pickar, M.D. Edinburgh 1938
 Norman Rosenberg, M.D.
 New York University 1938
 Jack E. Shangold, M.D. Tulane 1938

Monmouth County

Irving Baer, M.D. Tulane 1938

Leonard Schneider, M.D.
 New York University 1938
 Norman Davis Thetford, M.D. Cornell 1938

Morris County

James B. Cummins, M.D. Georgetown 1938
 Ralph L. Dicker, M.D. St. Louis 1938
 George Bache Emory, Jr., M.D. Columbia 1938
 E. Philip Gelvin, M.D. Vermont 1938
 Alvin Robert Mintz, M.D. Cornell 1938
 Morton Joseph Shanik, M.D. Nancy 1938

Ocean County

George J. Nichols, M.D. Hahnemann 1938
 John Vernet Prevost, M.D. Pennsylvania 1938
 Aram Martyr Sarajian, M.D. Maryland 1938

Passaic County

Edward W. Goldstein, M.D. Edinburgh 1938
 Morris A. Monaloy, M.D. New York Medical 1938
 Charles A. Nuzzolo, M.D. Bologna 1938
 Arnold Schleifer, M.D. Vienna 1938
 Irving A. Schultz, M.D. Cincinnati Eclectic 1938
 Louis Scovern, M.D. Glasgow 1938
 Edita S. Sporer, M.D. Czechoslovakia 1938
 L. Vincent Strully, M.D.
 University of New York 1938

Salem County

George A. Nitshe, Jr., M.D. Hahnemann 1938

Somerset County

Robert E. Bennett, M.D. Pennsylvania 1938
 C. Scott McKinley, M.D. Pennsylvania 1938
 Martin E. Tolomeo, M.D. Hahnemann 1938

Sussex County

Winton Hiram Johnson, M.D. Columbia 1938
 Edward Harry Weiser, M.D. Colorado 1938

Union County

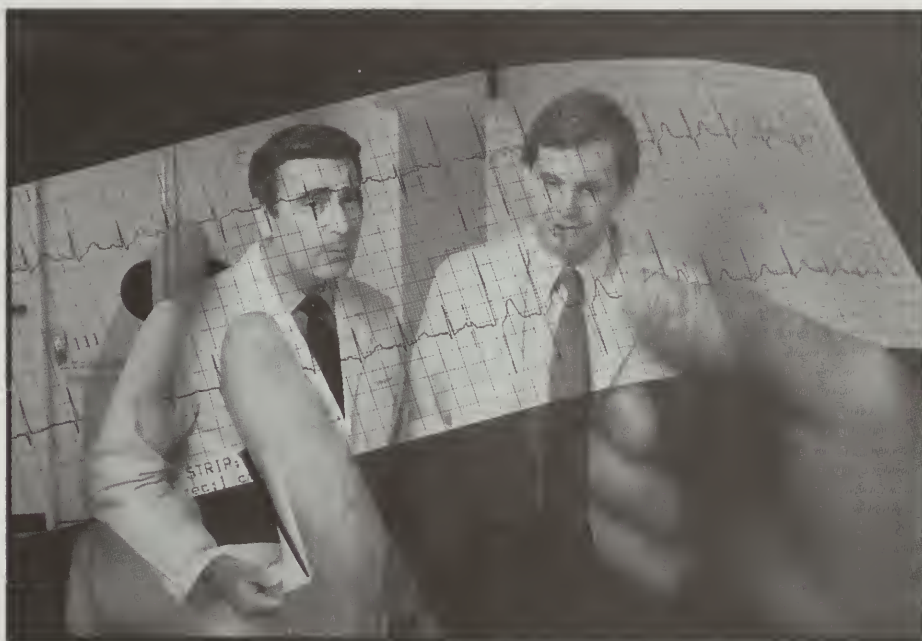
Anthony E. Abramo, M.D. Creighton 1938
 David S. Blatt, M.D. Brussels 1938
 Santiago Castanon, M.D. Havana 1938
 Gerald B. Demarest, M.D. Chicago 1938
 John J. Hamley, M.D. New York Medical 1938
 J. Roman Hrab, M.D. Poland 1938
 Dabney von K. Moon, M.D. Virginia 1938
 William L. Rumsey, Jr., M.D. Harvard 1938
 Howard P. Snyder, M.D. McGill 1938

Warren County

Walter A. Boquist, M.D. Jefferson 1938

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Governor Thomas H. Kean (right) signs bill in law as New Jersey State Medical Underwriters, Inc. President Peter Sweetland (left) and Chairman Henry J. Mineur, M.D. (center) look

DOCTORS' NOTEBOOK

*Trustees' Minutes; UMDNJ
Notes; MSNJ Auxiliary;
Physicians Seeking
Location in New Jersey*

Trustees' Minutes April 10, 1988

A regular meeting of the Board of Trustees was held on April 10, 1988, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Executive Committee . . . Approved the adoption of the following resolution:

Resolved, that the Medical Society of New Jersey reaffirm its endorsement of the Foundation of the University of Medicine and Dentistry of New Jersey, and express its strong support for the goals and purposes of the Foundation; and be it further

Resolved, that the Medical Society of New Jersey encourage its membership to make individual contributions to the Foundation; and be it further

Resolved, that available space in NEW JERSEY MEDICINE may be used from time to time to place public service "advertisements" to the membership, encouraging contributions to the Foundation.

Report of Executive Director . . .

(1) MSNJ Paid Membership . . . Noted that as of March 31, 1988, paid membership totals 6,659.

(2) MSNJ Financial Statements . . . Reviewed and approved the financial statements for the period ending February 29, 1988.

(3) SCI Update . . .

(a) Licensing Reform Legislation . . . Noted that no further information has been received from Senator Codey.

(b) State Board of Medical Examiners (SBME) . . . Asked Dr. Malta, President of SBME, to convey to the Federation of Licensing Boards, MSNJ's concern for preserving the confidentiality of medical information on individuals in voluntary treatment programs.

(c) Attorney General's Office . . . Noted Attorney General Office personnel are reviewing the SCI report and much sorting out will have to be done before this matter is introduced into the legislature.

(4) Meeting with Chief Justice Wilentz . . . Noted the following: Chief Justice Wilentz agreed to place on the court's rule-making agenda an item for discussion concerning MSNJ's and MIENJ's belief that Rule 4:21 in its pre-1984 form should be reinstituted as a mandatory procedure in New Jersey; Chief Justice Wilentz suggested that the approved format for requesting the court to consider a rule of evidence be followed, and that MSNJ will consider using that mechanism on the certificate of merit issue; and Chief Justice Wilentz offered to publish reminders to the Bar to investigate appropriately when filing a lawsuit, and after filing to have the lawsuit dismissed if in the course of discovery they cannot develop a case, and he indicated that defense attorneys that bill in excess of their time actually spent would be subject to discipline.

NJ Hospital Association (NJHA)

. . . Noted the following items: NJHA has designed a four-part workplan to expedite achievement of an 11 percent permanent, across-the-board hospital rate increase over and above the projected normal inflationary increases; a Medical Waste Fact-Finding Commission has been set up; and the NJHA Council on Planning's Subcommittee on AIDS has submitted a report recommend-

ing alternative levels of care and adequate health services for AIDS patients, and that incentives may be offered to institutions willing to expand their work with AIDS patients.

Council on Legislation . . . Approved all the positions recommended by the Council on Legislation with the exception of: S-1163 (Osteoporosis Study Commission), changed position to disapproved because osteoporosis is a well-known, researched, and publicized condition, and there is no need to create a special legislative commission to conduct studies when comprehensive, scientific literature readily is available; and, S-448 (Patient Rights), supported the Council's position, but added the following: conditional approval, pending deletion of the litigation option of the bill, since it will produce unnecessary delays and cost patients extra legal expense; furthermore, there should be a clause or section added to the bill recognizing that patients have certain obligations to cooperate in their treatment and to comply with advice and directions.

Committee on Finance and Budget

. . . Approved the following recommendations:

That the budget for fiscal year beginning June 1, 1988, and ending May 31, 1989, in the amount of \$3,750,000 with \$2,537,000 to be raised through member assessments be adopted.

That the 1989 assessments be set at \$350 per regular dues-paying member. (The 1988 assessment is \$330).

That the 1989 assessment be set at \$60 per member for affiliate members—no longer practicing in New Jersey. (The 1988 assessment was \$40).

That the 1989 assessment for associate members (interns-residents licensed in New Jersey) and licensed residents, provided the individual is in a residency program entered upon within a reasonable time after his or her graduation from medical school, be set at \$25. (No change from prior year).

That the 1989 assessment be set at \$10 per student for medical students. (No change from prior year).

Committee on Long-Range Planning and Development . . .

(1) Advisory Committee to the Auxiliary . . . Approved the following recommendation:

That the Advisory Committee to the Auxiliary be discontinued.

(2) Committee on Medical Student Loan Fund . . . Did not adopt the following recommendation:

That the Committee on Medical Student Loan Fund consist of two members, namely, a chairman and a vice-chairman, to be appointed by the President.

(3) Committee on Revision of Constitution and Bylaws and Committee on Long-Range Planning and Development: Noted that the Committee on Long-Range Planning and Development was opposed to the merger of its Committee with the Committee on Revision of Constitution and Bylaws.

(4) Committee on Child Health . . . Approved the following recommendations:

That the Special Committee on Child Health be discontinued.

That the activities of the Special Committee on Maternal and Child Care be expanded to include the Special Committee on Child Health.

(5) Committee on Occupational Health, Workers' Compensation, and Rehabilitation . . . Approved the following recommendations:

That the Special Committee on Occupational Health, Workers' Compensation, and Rehabilitation be discontinued.

That the activities of the Special Committee on Occupational Health, Workers' Compensation, and Rehabilitation be assumed by the Council on Medical Services.

(6) Ad Hoc Committee on Health Care Reimbursement Policies . . .

Noted that the following recommendations were not adopted. And, noted the Ad Hoc Committee on Health Care Reimbursement Policies will be disbanded, and the Council on Medical Services will assume responsibility for its activities and Dr. Formica will review membership and select individuals to serve on the council:

That the Ad Hoc Committee on Health Care Reimbursement Policies be changed to a permanent special committee of the Society, to be known as the Committee on Health Care Reimbursement Policies, to perform as originally charged.

(7) Speaker and Vice-Speaker of the House of Delegates . . .

(a) Speaker and Vice-Speaker Positions . . . Voted to postpone consideration of the following recommendations until the next regular meeting (following the Annual Meeting), when the speaker of the House can be present:

That the Speaker and Vice-Speaker be elected by the House of Delegates through the Society's Nominating Committee process.

That the term of office for the Speaker and Vice-Speaker be for two years, and that they be limited to three such terms.

(b) Ex Officio Seat on Board of Trustees . . . Voted to postpone consideration of the recommendation until the next regular meeting (following Annual Meeting), when the speaker of the House can be present to address the issue:

That the Speaker of the House of Delegates be given a non-voting, ex-officio seat on the Board of Trustees.

Committee on Cancer Control . . . Voted to postpone consideration of the following recommendation until the next regular meeting of the Board (following the Annual Meeting), when the chairman can be present to answer questions:

That the following amended version of Substitute Resolution #15, Infusaid Pump Recognition, be approved:

Whereas, the use of implantable infusion pump (i.e. Infusaid) for certain chemotherapy treatments has had acceptance by the medical community, as well as approval and payment by third-party insurers; and

Whereas, the use of such pumps for the control of pain utilizing morphine infusion has been shown to be of great benefit for the treatment of chronic pain; now therefore be it

Resolved, that the Medical Society of New Jersey urge the State Department of Insurance to do all in its power to make the use of implantable infusion pumps available to New Jersey residents for intrathecal or epidural administration of morphine for the treatment of intractable pain due to cancer.

Committee on Conservation of Vision . . . Approved the following recommendation:

That the 1988 Eye Health Screening Program be held the week of September 26, 1988.

Task Force on AIDS . . . Adopted the recommendations and statements of the Task Force; the entire report will be published in the *Transactions*.

Senior Medical Courtesy Program . . . Received as informational, the results of a survey measuring the effectiveness of the Senior Medical Courtesy Program.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

The first program in New Jersey to train physicians in the specialty of neurosurgery has been approved for the Newark campus of UMDNJ by the American Board of Neurological Surgery. The six-year program will begin July 1 at University Hospital.

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of the Board, the hospital had to attain a volume of several hundred sophisticated neurosurgical procedures a year, covering a full spectrum of neurosurgical diseases. The residency program is the first such residency approved in many years in this specialty.

University Hospital will be the site of most of the clinical training in direct patient care and management and in operative procedures. Two six-month periods of clinical training will take place at Saint Barnabas Medical Center, Livingston, an affiliated teaching hospital.

The accreditation recognizes the growing magnitude and sophistication of neurosurgery at University Hospital since the section was launched in 1974 by Abbott J. Krieger, M.D. Dr. Krieger, director of the program and professor of surgery at UMDNJ-New Jersey Medical School, also is codirector of University Hospital's neuro-intensive care unit, one of the most advanced in the country. The unit contains eight individually monitored bed-stations. A computerized evoked-potential monitor used in the unit and in the operating room can follow faint nervous system electrical signals and transmit information to locate and identify injuries.

Through such instrumentation and advances in imaging with computerized tomography (CT) scanning and magnetic resonance imaging (MRI), neurosurgery has become a particularly high-tech specialty. Conventional surgery, for example, now is supplemented by such equipment as carbon dioxide lasers, more exact than a scalpel, and stereotaxis, a method to reach accurately and safely the deepest portion of brain tissue needed for biopsy.

As a result of the new capabilities, some formerly inoperable conditions can be addressed. Certain brain tumors, previously not treatable, can be removed, or a life-threatening aneurysm can be repaired by the new techniques.

Dr. Krieger has appointed Otakar R. Hubschmann, M.D., professor of surgery at the medical school, to serve as the educational director of the training program at Saint Barnabas Medical Center. Dr. Hubschmann has been actively developing the neurosurgical clinical program at Saint Barnabas since 1986.

Another "first" recorded by

UMDNJ in recent weeks was the opening of New Jersey's first countywide program to treat mentally ill chemical abusers, known as MICA patients. The Camden County program, supported by a \$200,000 grant from the state's Departments of Human Services and Health, is based at the Cherry Hill Division of Kennedy Memorial Hospitals-University Medical Center, an affiliate of our School of Osteopathic Medicine. The funding will allow for the renovation of a 6,000 square-foot facility, with separate entrance, near the hospital's existing inpatient psychiatric and alcohol/drug rehabilitation units. The program will be ad-

ministered by project directors from the UMDNJ-Community Mental Health Center at Piscataway.

Finally, special tips-of-the-hat to two faculty members at our Newark-based UMDNJ-New Jersey Medical School, Drs. William E. Neville and James Oleske.

Dr. Neville, professor of surgery who joined the faculty in 1971, has been awarded the Sir William Osler Humanitarian Award by the American Lung Association of New Jersey.

Dr. Oleske, director of pediatric allergy, immunology, and infectious diseases at the Newark campus, was among ten New Jerseyans to receive a 1988 Pride Award.

MSNJ Auxiliary

Mrs. Angie Campo, President

At the Annual Session of the Medical Society of New Jersey Auxiliary, Mrs. Frank Campo was installed as the 62nd president and was the 6th Auxiliary member from Mercer County to hold that honor.

Angie Campo is a graduate of the Trenton Public School system and the Georgetown University School of Nursing. After working as assistant night supervisor and coordinator of the student health program at Georgetown University Hospital, she returned to New Jersey. In Trenton, she worked in the operating room at St. Francis Medical Center where she met and married pathology resident, Frank Campo. When their three daughters, Alessandra, Julie, and Frances, were of school age, Angie became chairman of the PTA Health program. At the same time, she became active with the Mercer County Medical Society Auxiliary; she was president when the Medical Society and the Auxiliary worked together on the pilot program for Colorectal Cancer Screening.

Angie also has been president of the St. Francis Medical Center Auxiliary; an officer of the Council on Auxiliaries of the New Jersey Hospital Association; and presently, is a Reach to Recovery Volunteer with the Mercer County Chapter of the American Cancer Society.

In all of her activities she has been greatly supported by her daughters and by her husband. Dr. Campo has served the medical community as President of the Mercer County Medical Society and as a member of the Medical Society of New Jersey



Mrs. Angie Campo

Board of Trustees for nine years.

Although Angie has been more active in health-related projects, one of the most enjoyable and satisfying ones had nothing to do with medicine. Through the Central Jersey Chapter of the American Italian Historical Association, she was chairperson of a committee that published posthumously a collection of delightful and moving vignettes written by a friend and former teacher about his experiences growing up in the Italian section of Trenton.

The Campo family enjoys traveling and all three daughters share Angie's hobby of needlepoint. However, Angie is the one who is addicted to British mystery stories; it was this enthusiasm that once took Frank and her on a wandering tour of the old halls of Saint Bartholomew's Hospital in London. They eventually reached the laboratory where a wall plaque commemorates the official, first meeting of John H. Watson, M.D., and Sherlock Holmes.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY—Jerry Michael Shier, M.D., 11546 February Cir., Apt. 202, Silver Spring, MD 20904. UMDNJ 1982. Also, clinical immunology. Board eligible. Board certified (PED). Group, partnership, solo. Available July 1988.

ANESTHESIOLOGY—Kenneth Lum, M.D., 7240 Twin Eagle Lane, Fort Myers, FL 33912. Downstate 1985. Board eligible. Available.

CARDIOLOGY—Donald G. Rubenstein, M.D., 1037 3rd St., #303, Santa Monica, CA 90403. Louisiana 1980. Board eligible. Group or partnership. Available August 1988.

DERMATOLOGY—Cheryl S. Citron, M.D., 885 Sussex Rd., San Marino, CA 91108. Miami 1984. Board eligible. Group, partnership, solo. Available July 1988.

ENDOCRINOLOGY—Robert P. Castellucci, M.D., 3509 Kensington Ave., #3, Richmond, VA 23221. St. George's 1982. Board eligible. Partnership or group. Available September 1988.
Gerald B. Miele, M.D., 110 Fleet Pl., Mineola, NY 11501. Rush 1983. Also, internal medicine. Board eligible. Partnership, group, solo. Available July 1988.

FAMILY MEDICINE—Roy Berkowitz-Shelton, M.D., 132 Grove Pk., Ft. Dix, NJ 08640. Georgetown 1981. Board certified. Partnership. Available.

Serge I. Kaftal, M.D., 30 South Auten Ave., Somerville, NJ 08876. Lodz (Poland) 1980. Board eligible. Solo, partnership, group. Available November 1988.

GASTROENTEROLOGY—Anil Agarwal, M.D., 18 Maltese Dr., Fair Lawn, NJ 07410. LLRM Medical (India) 1979. Also, internal medicine. Board eligible. Board certified (IM). Available July 1988.

David Rosenbock, M.D., 5 Riggs Pl., West Orange, NJ 07052. UMDNJ. Board eligible. Board certified (IM). Group, partnership, solo. Available July 1988.

INTERNAL MEDICINE—Anil Agarwal, M.D., 18 Maltese Dr., Fair Lawn, NJ 07410. LLRM Medical (India) 1979. Also, gastroenterology. Board certified. Available July 1988.

Paul R. Axelrad, M.D., 666 Ninth St., Lakewood, NJ 08701. St. George's University 1985. Board eligible. Group or partnership. Available July 1988.

Marc Hanfling, D.O., 26 Glen Lane, Cherry Hill, NJ 08002. New York College 1981. Also, cardiology. Board certified. Board eligible (CARD). Group, partnership, solo. Available.

Lalitha B. Iyer, M.D., 84 Hempstead Dr., Somerset, NJ 08873. Madras (India) 1980. Board eligible. Group, partnership, emergency room. Available July 1988.

Peter Kuzmick, D.O., 62 Diamond Ave., Fort Rucker, AL 36362. Kansas City College 1980. Board certified. Group or partnership. Available July 1988.

Gerald B. Miele, M.D., 110 Fleet Pl., Mineola, NY 11501. Rush 1983. Also, endocrinology. Board eligible. Partnership, group, solo. Available July 1988.

Edward C. Phillips, M.D., 24 Walnut St., Summit, NJ 07901. Downstate 1984. Board eligible. Group, partnership, solo. Available July 1988.

Joseph T. Wayne, M.D., 106 Elmwood Dr., Prudenville, MI 48651. SUNY-Buf-

falo 1982. Board eligible. Board certified (PED). Also, pediatrics. Group, partnership, academic. Available October 1988.

PEDIATRICS—Linda York-Chance, M.D., 435 East 70th St., New York, NY 10021. Connecticut 1985. Board eligible. Clinic or emergency room. Available July 1988.

Joseph T. Wayne, M.D., 106 Elmwood Dr., Prudenville, MI 48651. SUNY-Buffalo 1982. Also, internal medicine. Board certified. Board eligible (IM). Group, partnership, academic. Available October 1988.

PSYCHIATRY—Jozsef Telkes, M.D., c/o John Black, 3901 Crosswicks-Hamilton Square Rd., Robbinsville, NJ 08691. Pecs (Hungary) 1978. Board certified. Group or research. Available September 1988.

SURGERY—James H. Frost, M.D., 655 W. Irving Pk. Rd., Apt. 4306, Chicago, IL 60613. Guadalajara; Mt. Sinai Fifth Pathway 1983. Board eligible. Group or partnership. Available July 1988.

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11TH ANNUAL CURRENT CONCERNS IN ADOLESCENT MEDICINE—"A PRACTICAL APPROACH TO CURRENT PROBLEMS IN ADOLESCENTS"—September 29 & 30, 1988, The New York Hilton, New York, NY. Sponsored by: Division of Adolescent Medicine, Schneider Children's Hospital of Long Island Jewish Medical Center, New Hyde Park, NY. Topics include: Special Concerns for the Physician; Adolescent Gynecology; Eating Disorders; Growth Problems; AIDS; Adolescent Hypertension; Suicide; Cholesterol & Lipids; Screening & Management and more. Credits: 12 Category 1 from the ACCME and AMA. Information: Ann J. Boehme, Associate Director for Continuing Education, Schneider Children's Hospital of Long Island Jewish Medical Center, New Hyde Park, NY 11042; (718) 470-8650.

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CME CALENDAR

The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization for further information.

DERMATOLOGY

July

- 26 Update on Superficial Fungal Infections**
3-4 P.M.—Maple Hall, Developmental Center at Ancora, Hammonton (AMNJ)

MEDICINE

July

- 1 Advanced and Real Time, Cross-Sectional Section Scanning**
8:30 A.M.-5 P.M.—Sands Hotel & Casino, Atlantic City
(National Foundation for Noninvasive Diagnostics)
- 1 AIDS**
12 noon-1 P.M.—Freehold Area Hospital, Freehold (AMNJ)
- 13 AIDS**
8 A.M.-9 P.M.—Southern Ocean County Hospital, Manahawkin (AMNJ)
- 15 AIDS**
1:30-2:30 P.M.—Trenton Psychiatric Hospital, Trenton (AMNJ)
- 20 Wound Healing and Pressure Sores**
12 noon—Robert Wood Johnson Medical School, Medical Education Building, New Brunswick (UMDNJ)
- 25- Sexuality Today: Fifth Annual**
27 Summer Institute for Educators and Counselors
9 A.M.—Douglass College, New Brunswick (UMDNJ)

August

- 8 AIDS**
7-8 P.M.—Wallkill Valley General Hospital, Sussex (AMNJ)
- 16 Calcium Channel Blockers in the Elderly**
7:30-8:30 A.M.—Mercer Medical Center, Trenton
(Mercer Medical Center/Glaxo Pharmaceuticals)

PEDIATRICS

July

- 28 Child Sexual Abuse**
9 A.M.—Robert Wood Johnson Medical School, New Brunswick (UMDNJ)

PSYCHIATRY

July

- 7 Treating Panic Disorder and Agoraphobia**
12 noon-1 P.M.—Carrier Foundation, Belle Mead (Carrier Foundation)
- 14 Assaults on Staff by Psychiatric Patients**
12 noon-1 P.M.—Carrier Foundation, Belle Mead (Carrier Foundation)
- 21 Geriatric Patients**
12 noon-1 P.M.—Carrier Foundation, Belle Mead (Carrier Foundation)

August

- 4 New Developments in Substance Abuse**
12 noon-1 P.M.—Carrier Foundation, Belle Mead (Carrier Foundation)
- 11 Psychopharmacologic Approaches to Dual-Diagnosis**
12 noon-1 P.M.—Carrier Foundation, Belle Mead (Carrier Foundation)
- 18 Families of Adolescent Addicts**
12 noon-1 P.M.—Carrier Foundation, Belle Mead (Carrier Foundation)

UROLOGY

July

- 22 Clinical Cases Presentation**
6:30-7 P.M.—Robert Wood Johnson Medical School, New Brunswick (UMDNJ)

August

- 24 Clinical Cases Presentation**
6:30-7 P.M.—Robert Wood Johnson Medical School, New Brunswick (UMDNJ)

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LETTERS TO THE
EDITOR



Dr. David Eckstein

March 23, 1988

Dear Doctor Krosnick:

The obituary you published in the March issue of *NEW JERSEY MEDICINE* about David Eckstein was very well done. I am writing to say that I would like to add an "if only" to the story of David Eckstein, physician. If only I had videotaped this man!

It was my privilege to know and to work with Dave Eckstein from 1968 until his retirement as the medical director at Meadow Lakes and then to see him from time to time in other capacities until near the time of his death. This courtly gentleman of small stature and great heart was a man whose love for his patients, especially the elderly, sparkled from his eyes and leaped from his touch. His measured and mellow deep voice calmed many a fear and soothed all. He fought for the elderly and the poor on all fronts. He could be moved to tears of anger when recounting examples of lapses of medical professionalism or absent integrity. David's bedside manner was wonderful.

Dave Eckstein faced major illness and surgery with great strength and courage. He was so very careful about the feelings of those he entrusted with his care. If only he

could be heard and seen today by the medical students we are teaching and the residents who thirst for bedside rounds with experienced clinicians. This clinician with the shock of white hair and measured tones was a consummate listener and a diagnostician of note. We are so much richer that he came this way.

(signed) James J. Chandler

Caesarean Sections

February 17, 1988

Dear Doctor Krosnick:

Your readers may be interested in a brief report on the gradually increasing percentage of caesarean (C) sections in New Jersey from 1980 to 1987.

Data were reviewed on claims paid by Blue Cross and Blue Shield of New Jersey from 1980 through 1987 for vaginal delivery and C/section. Nationwide trends are verified by our data, as indicated below. We note C/section percentage somewhat higher than reported nationally.

Year	Vaginal Delivery	C/Section
1980	24,673	6,770
1981	26,678	7,333
1982	25,765	7,778
1983	24,455	7,731
1984	23,195	8,090
1985	24,164	8,683
1986	22,093	8,762
1987	22,067	9,454

Year	Total	% C/Section
1980	31,443	21.5
1981	34,011	21.6
1982	33,543	23.2
1983	32,186	24.0
1984	31,285	25.9
1985	32,847	26.4
1986	30,855	28.4
1987	31,521	29.99

Reasons for increasing numbers of C/sections are under debate elsewhere. This letter is merely to report statistics. We are monitoring areas where utilization seems unusually high.

(signed) Charles L. Cuniff, M.D.

Viral Diagnostics

March 8, 1988

Dear Doctor Krosnick:

During the fourth year of operation, UMDNJ-Robert Wood Johnson Medical School Viral Diagnostic Laboratory identified 384 viruses from a total number of 1,808 specimens submitted, for an isolation rate of 21 percent. As was true during the past several years, herpes simplex virus continues to be the predominant virus isolated. However, this year it accounted for 47 percent of viruses isolated as contrasted to last year when it accounted for 58 percent of viruses isolated. The second most prevalent virus this year was respiratory syncytial virus (RSV), ranked only fourth during the 1986 calendar year, reflecting an unusually severe epidemic of moderate to severe RSV pneumonitis and bronchiolitis in infants and children at the close of 1987. The third most common virus isolated was cytomegalovirus (CMV), accounting for 18 percent of the isolates, both this past calendar year and for calendar year 1986.

Specimens Submitted for Viral Identification—1987	
Total Submitted	1,808
Viruses Identified	384
Percent Positive	(21%)
Herpes Simplex Virus	179
Respiratory Syncytial Virus	75
Cytomegalovirus	69
Rotavirus	37
Enterovirus	15
Herpes Varicella Zoster Virus	5
Adenovirus	3
Influenza Virus	1

Rotavirus came in fourth, enterovirus remained in fifth place, with herpes varicella zoster virus, adenovirus, and influenza virus bringing up the rear. It is our goal this year to continue to offer high-quality, rapid viral diagnostic services to hospitals and physicians in central New Jersey and to make readily available rapid viral diagnosis of the human immunodeficiency virus. We hope this information is of interest to the physicians of New Jersey.

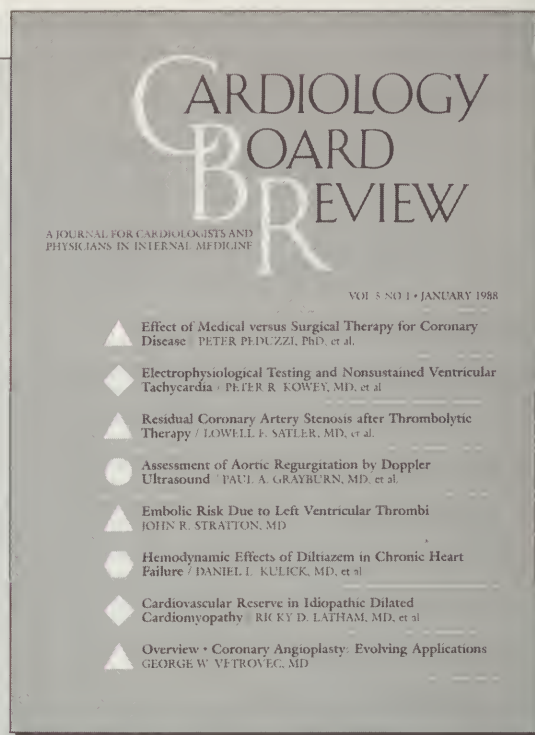
(signed) Lawrence D. Frenkel, M.D.
Director, Laboratory for Clinical Virology

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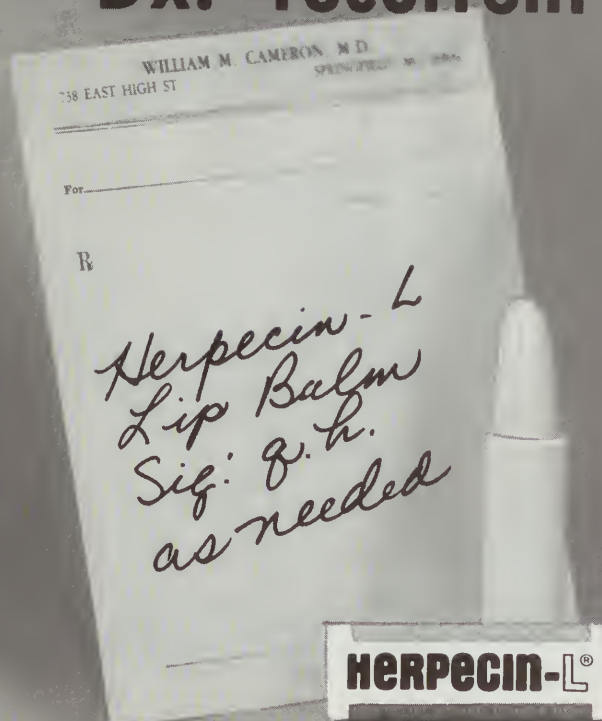
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* Journals reviewed include: *Circulation*, *American Heart Journal*, *Journal of the American College of Cardiology*, *British Heart Journal*, *Chest*, *The American Journal of Cardiology*, *The New England Journal of Medicine*, *Annals of Internal Medicine*, *American Journal of Medicine*, and *The Journal of the American Medical Association*.

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BOOK REVIEWS

Dermatology for the House Officer; Magnetic Resonance Imaging of the Knee; Magnetic Resonance of the Musculoskeletal System; Manual of Dermatologic Therapeutics; MRI of the Body; Organ Transplantation and Replacement; Pediatric Neurology and Neuroradiology

Dermatology for the House Officer

Peter J. Lynch, M.D. Baltimore, MD, Williams & Wilkins, 1987. Pp. 353. (\$13.95)

Five years after publication of the successful initial offering, this is an updated second edition of a very educational handbook. With a little effort, and use of this pithy guide, one can develop lasting skills in recognizing almost all common skin problems, and appreciate the important signs of internal diseases. The physician is taught, step-by-step, how to examine skin carefully, observe and describe lesions, and then chart a mental course to the correct diagnosis. The simplicity, and utility, of this systematic approach is emphasized by the lack of a single clinical photograph within the volume. Sufficient dermatopathological and pathological material amplifies each subject and leads to a considered discussion of therapeutic options. Current references and additional reading suggestions point to worthwhile sources of supplemental information. This pocket-sized treasure is a compressed, full course in dermatological basics. The paper, printing, and layout are just serviceable, keeping production costs low. This is a best buy.

Christopher M. Papa, M.D.

Magnetic Resonance Imaging of the Knee

Jerold H. Mink, Murray A. Reicher, John V. Crues, III. New York, NY, Raven Press, 1987. Pp. 178. (\$79.50)

The authors of this work have assembled an excellent review of a technique that at many centers is replacing conventional arthrography. The introductory discussion of physics gives the reader a practical understanding of the role of technical parameters in image quality. A list of various imaging protocols is included. (Some institutions also use fast field echo techniques.)

While the body of the book reviews a broad spectrum of topics, it stresses meniscal and ligamental diseases. In addition to being well-written and displaying scans of good quality, the book also includes pathological photographs. A chapter entitled, "Pitfalls in Interpretation," includes a review of normal variants and artifacts.

This timely and clinically oriented text is highly recommended to physicians who have an interest in this area.

Neil B. Horner, M.D.

Magnetic Resonance of the Musculoskeletal System

Thomas H. Berquist, Richard L. Ehman, Michael L. Richardson (eds). New York, NY, Raven Press, 1987. Pp. 220. (\$28)

This small, inexpensive monograph provides an overview of the role that magnetic resonance imaging (MRI) plays in the evaluation of the musculoskeletal system.

Beginning with a review of the basic theory of MRI, the treatise also includes a discussion about interpretation that is very informative.

The range of topics includes tumor, infection, trauma, and the spine, and the scans display good quality. To our advantage, the clearly written text makes reference to other modalities. For example, the chapter entitled, "Miscellaneous Conditions and Future Potentials," includes a concise review of osteonecrosis. I would have liked to see further attention given to the diseases of the various joints.

In all, the book is recommended for the physician who desires a brief introduction to this area.

Neil B. Horner, M.D.

Manual of Dermatologic Therapeutics. With Essentials of Diagnosis. Third Edition

Kenneth A. Arndt, M.D. Boston, MA, Little, Brown and Co., 1983. Pp. 347.

Near the turn of this century, the late W. A. Pusey, M.D., stated, "Skin diseases occur on the surface of the body where everyone can see them, but few recognize them. Because of the first fact and despite the second fact, most physicians are inclined to treat them." Current proof of this aphorism lies in the success of this manual, now in the third printing of its third edition.

As the title proclaims, this text is heavy on treatment and light on diagnosis. It is an attractive, spiral bound, pocket volume with 17 small color photographs contained in its four central pages. (The latter are as useful as a dollop of whipped cream on top of a crock of baked beans, being decorative, out of place, and an unnecessary expense.)

Dr. Arndt, Professor at Harvard Medical School, and current editor of the *Archives of Dermatology*, has labored earnestly in producing his authoritative opus. Unfortunately, it will be of rather limited educational value to most nondermatologists, for it fails to instruct simply in the basics. The principles of dermatological therapy, particularly the selection of appropriate vehicles, is a particularly weak section, and should be the strongest. Some of the information is so overwhelming that it surely will discourage anyone less than a skin specialist. The entry on isotretinoin, which leads the listing of acne preparations in the formulary section, is a good example. While it is a retinoid of prodigious utility, the catalogue presented could only warm the heart of another dermatologist. It might be nice to know that it finds use in pityriasis rubra pilaris, epidermolytic hyperkeratosis, Darier's disease, keratosis palmaris et plantaris, congenital ichthyosiform erythroderma, dissecting cellulitis of the scalp, and hidradenitis suppurativa, but the student cannot find necessary information on these conditions in the manual.

There is an admirable attempt to deal with the economics of prescriptions by providing prices of various

therapies, but the information becomes obsolete before it is printed.

The major fault of this manual is that the therapeutic information, likewise, is out-of-date. What was best in 1983, may be inappropriate five years later. The section on herpes simplex fails to include oral acyclovir therapy because it wasn't available when the text was prepared, and there is no effort to correct the omission with the new printing.

Dermatology for the House Officer (2nd Edition) remains a much better buy, and my pick as dermatology manual-of-choice.

Christopher M. Papa, M.D.

MRI of the Body

Charles B. Higgins, M.D. and Hedvig Hricak, M.D. (eds). New York, NY, Raven Press, 1987. Pp. 608. (\$125)

The editors of *MRI of the Body* are from the University of California, San Francisco; the contributing editors are based worldwide.

At a time when magnetic resonance imaging (MRI) of the body is becoming a more important tool in clinical evaluation, this text is useful. Beginning chapters, Wehrli's on fast field echo techniques and von Schultheiss's on blood flow, provide a review of physics. Broad in scope, the text reviews MRI of the neck, thorax (including the heart), breasts, abdomen, pelvis, vascular system, musculoskeletal system (including joints), and the spine. The cardiac section is divided into acquired diseases, congenital diseases, and "cine" imaging. A chapter on obstetrical MRI that at present has limited clinical usefulness also is included. The book's chapters are

abundant in their amount of state-of-the-art images; the text is clinically oriented and well-written. Technical discussions are kept to a minimum.

The book is highly recommended to the physician who wishes a good clinical basis to the field.

Neil B. Horner, M.D.

Organ Transplantation and Replacement

G. James Cerilli, M.D. Philadelphia, PA, J. B. Lippincott Company, 1988. Pp. 732. (\$95)

This text in 49 chapters achieves the author's goal: it summarizes the pertinent science of transplantation and transplant immunology. Renal transplantation is covered in detail and other organ transplants (heart, liver, pancreas, lung, skin, bone, bone marrow, cornea, and small bowel) are covered in dedicated chapters. Finally, artificial organs are exemplified by chapters devoted to the artificial heart and insulin delivery systems. Separate chapters devoted to ethics and legal issues round out the text. I especially appreciated the chapter authored by Francis Moore which outlines the evolution of this exciting field.

The charts and graphs generally are clear but many are peculiar to clinical transplantation and may be confusing to the uninitiated. The black-and-white photomicrographs surprisingly are good. Other illustrations, especially the line drawings, are excellent.

There is an enormous fund of information contained in this volume, probably collected by endless library hours reviewing literature. Cerilli has assembled the best authorities

in the field and distilled their work into a very useful reference. This text will be invaluable to any clinician involved with the care of transplant patients. It also would be a good addition to any hospital library.

Dennis Filippone, M.D.

Pediatric Neurology and Neuroradiology

C. Diebler and O. Dulac. New York, NY, Springer-Verlag, 1987. Pp. 408. (\$165)

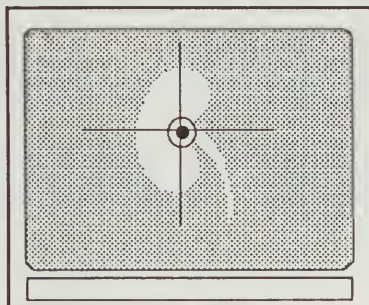
The work of two French physicians, this book is an orderly and well-illustrated radiologic correlation of the neurologic diseases of childhood.

Its sections include malformations, neurocutaneous syndromes, metabolic diseases, infections, vascular diseases, tumors, and trauma. Further subdivisions are devoted wholly to the diseases and their clinical aspects, reviewing them in a concise and clear style. The neuroradiologic discussion almost exclusively is centered around computed tomography. Unfortunately, MRI is not included. The scans are of very good quality, and the generous inclusion of so many gives the book a text-atlas format. There are some variations in the authors' terminology vis-à-vis what is commonly used in this country. For example, Chiari malformations are listed under Cleland-Chiari malformations.

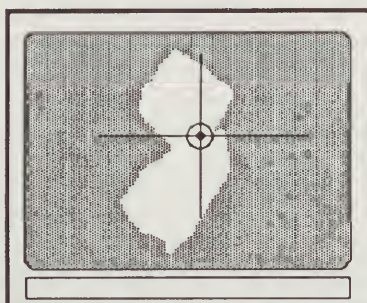
The authors have compiled a useful monograph that integrates the clinical aspects of the disease entities with CT findings. The book is highly recommended.

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***Drs. Bristol; Demy;
Hutchinson; Stein;
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Dr. Frank E. Bristol, II

General practitioner Frank Ernest Bristol, II, M.D., died on March 4, 1988, at the age of 74. Born in Philadelphia, Dr. Bristol received his medical degree in 1939, from Hahnemann Medical College and Hospital, Philadelphia. He maintained a medical practice in Dayton, retiring in 1979. Dr. Bristol later was associated with a practice at the Rossmoor Medical Center, and for the last five years was employed by Sera-Tech Laboratories, North Brunswick. During World War II, Dr. Bristol served in the United States Army medical corps as a lieutenant-colonel. He was a member of our Middlesex County component and of the American Medical Association.

Dr. Nicholas G. Demy

Radiologist Nicholas George Demy, M.D., died on February 24, at the age of 83. Born in Austria-Hungary, Dr. Demy emigrated to the United States in 1912, and received his medical degree from Marquette University School of Medicine, Milwaukee, Wisconsin, in 1943. During World War II, he was a captain in the United States Army medical corps stationed in Okinawa. Following the war, Dr. Demy joined the late Dr. James Boyes in a radiology practice at Muhlenberg Medical Center,

Plainfield, and at Somerset Medical Center, forming Associated Radiologists. Dr. Demy was chief of radiology at Somerset Medical Center, until retiring in 1974, when he moved to East Hampton. During his years of medical practice, Dr. Demy visited many Third World nations, serving as a medical ambassador to help modernize medical facilities. Dr. Demy was a member of the Bridgewater Township Board of Health from 1949 to 1957, and taught for many years at Bellevue Hospital, New York. A diplomate in radiology, and a fellow of the American College of Radiology, Dr. Demy was a member of the Radiological Society of New Jersey, serving as secretary, vice-president, and president; of our Somerset County component; and of the American Medical Association.

Dr. George F. Hutchinson

Retired eye, ear, nose, and throat specialist George Forman Hutchinson, M.D., died on April 3, 1988, at the age of 85. A Robbinsville native, Dr. Hutchinson received his medical degree from Hahnemann Medical College and Hospital, Philadelphia, in 1928. After an internship with McKinley Hospital (now Helene Fuld Medical Center), Dr. Hutchinson maintained the affiliation, serving as the Hospital's department chief. He was a member of the clinical staff of Wills Eye Hospital, Philadelphia, and was school physician for both West Windsor and Washington Townships. A charter member of the New Jersey Academy of Ophthalmology and Otorhinolaryngology, Dr. Hutchinson also was a member of our Mercer County component and of the AMA. During World War II, Dr. Hutchinson was a captain in the United States Army medical corps. In 1978, he received MSNJ's Golden Merit Award for 50 years of medical practice.

Dr. Martin H. Stein

Retired surgeon Martin Henry Stein, M.D., of Elizabeth, died on January 19, 1988, at the age of 97. A native of Lithuania, Dr. Stein received his medical degree from Medico-Chirurgical College of Philadelphia, Pennsylvania, in 1914. Affiliated with St. Elizabeth Hospital, Dr. Stein was a fellow of the American College of Surgeons, and was a member of our Union County Com-

ponent and of the AMA. During World War I, Dr. Stein served on active duty with the United States Army medical corps, emerging with the rank of lieutenant. He received the Golden Merit Award in 1964.

Dr. Lawrence Strenger

Former chief of neurosurgery at both Atlantic City Medical Center and Shore Memorial Hospital, Somers Point, Lawrence Strenger, M.D., 57, died on March 26, 1988 following a lengthy illness. Born in New York, Dr. Strenger received his medical degree from the Chicago College of Medicine and Surgery, Illinois, in 1955. He maintained an Atlantic City private practice for some years, and was affiliated with several hospitals as a consulting neurosurgeon: Burdette Tomlin Memorial Hospital, Cape May Court House; Ancora Psychiatric Hospital, Hammonton; William B. Kessler Memorial Hospital, Hammonton; Community Memorial Hospital, Toms River; and Kimball Medical Center, Lakewood. A diplomate in neurological surgery, Dr. Strenger was a fellow of the American College of Surgeons. The recipient of numerous medical fellowships, Dr. Strenger was a member and past-president of the Atlantic County Medical Society and of the New Jersey Neurological Society, and founder of the Society for Neurovascular Surgery. He was a member of the New Jersey Neurological Society, the Medical Society of New Jersey, the Society of Surgeons of New Jersey, the Pan American Medical Association, the Congress of Neurological Surgeons, the Mid-Atlantic Neurosurgical Society, the Philadelphia Neurosurgical Society, the New York Neurosurgical Society, and several other organizations. Dr. Strenger was past surgical vice-president and treasurer of Atlantic-Cape May Health Services, and was a founding member of the South Shore Health Plan for Atlantic-Cape May MRI. He was appointed to the New Jersey Emergency Medical Task Force and the Joint Council of State Neurosurgical Societies of which he was past chairman of the Northeast quadrant. From 1957 to 1959, Dr. Strenger was a United States Air Force captain, serving as physician and assistant chief of surgical services at Lockbourne Air Force Base. He was a member of our Atlantic County component and of the AMA.

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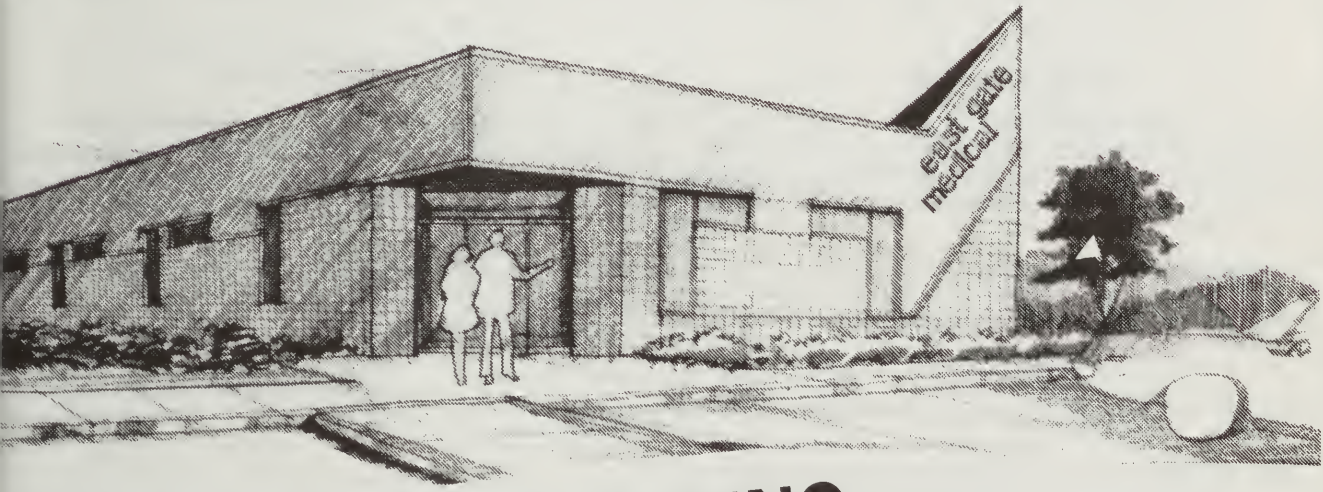
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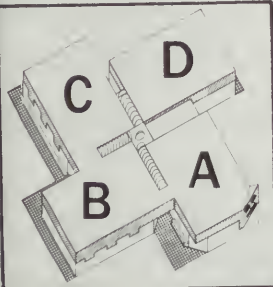
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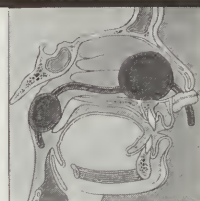
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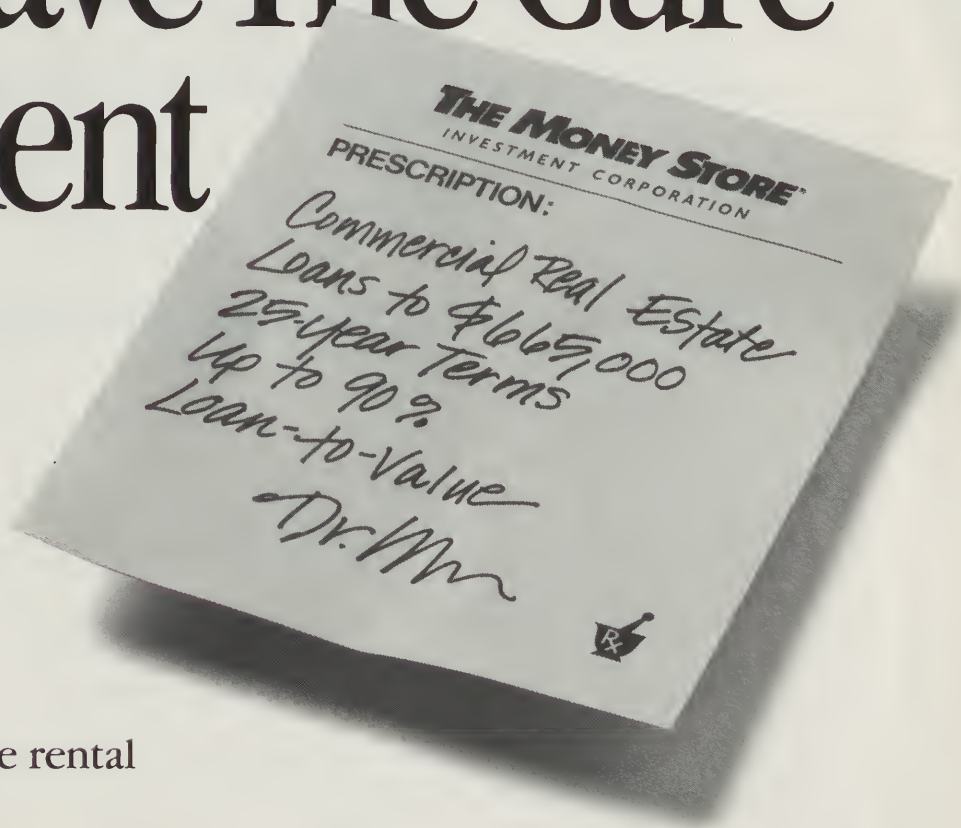
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JULY 1988

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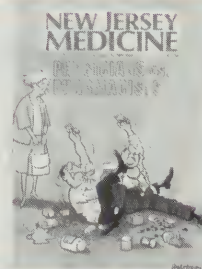
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On The Cover: Our story on drug dispensing by physicians and pharmacists begins on page 589. Cover: Deb Polston.



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Sustained Action Tablets

INDICATIONS: THEO-DUR is indicated for relief and/or prevention of symptoms of asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

CONTRAINDICATIONS: THEO-DUR is contraindicated in individuals who have shown hypersensitivity to theophylline or any of the tablet components.

WARNINGS: Status asthmaticus should be considered a medical emergency and is defined as that degree of bronchospasm which is not rapidly responsive to usual doses of conventional bronchodilators. Optimal therapy for such patients frequently requires both *additional medication*, parenterally administered, and *close monitoring*, preferably in an intensive care setting.

Although increasing the dose of theophylline may bring about relief, such treatment may be associated with toxicity. The likelihood of such toxicity developing increases significantly when the serum theophylline concentration exceeds 20 mcg/ml. Therefore, determination of serum theophylline levels is recommended to assure maximal benefit without excessive risk.

Serum levels above 20 mcg/ml are rarely found after appropriate administration of recommended doses. However, in individuals in whom theophylline plasma clearance is reduced for *any reason*, even conventional doses may result in increased serum levels and potential toxicity. Reduced theophylline clearance has been documented in the following readily identifiable groups: 1) patients with impaired renal or liver function; 2) patients over 55 years of age, particularly males and those with chronic lung disease; 3) those with cardiac failure from any cause; 4) neonates; and 5) those patients taking certain drugs (macrolide antibiotics and cimetidine). Decreased clearance of theophylline may be associated with either influenza immunization or active infection in the above individuals. Less serious signs of theophylline toxicity (i.e. nausea and restlessness) may occur frequently when initiating therapy, but are usually transient; when such signs are persistent during maintenance therapy, they are often associated with serum concentrations above 20 mcg/ml. Unfortunately, however, serious side effects such as ventricular arrhythmias, convulsions or even death may appear as the first sign of toxicity without any previous warning. Stated differently: *serious toxicity is not reliably preceded by less severe side effects*.

Many patients who require theophylline may exhibit tachycardia due to their underlying disease process so that the cause/effect relationship to elevated serum theophylline concentrations may not be appreciated.

Theophylline products may cause dysrhythmia and/or worsen pre-existing arrhythmias and any significant change in rate and/or rhythm warrants monitoring and further investigation.

The occurrence of arrhythmias and sudden death (with histological evidence of necrosis of the myocardium) has been recorded in laboratory animals (monkeys, rodents and dogs) when theophylline and beta agonists were administered concomitantly, although not when either was administered alone. The significance of these findings when applied to human usage is currently unknown.

PRECAUTIONS: THEO-DUR TABLETS SHOULD NOT BE CHEWED OR CRUSHED.

General: Theophylline half-life is shorter in smokers than in non-smokers. Therefore, smokers may require larger or more frequent doses. Morphine and curare should be used with caution in patients with airway obstruction as they may suppress respiration and stimulate histamine release. Alternative drugs should be used when possible. Theophylline should not be administered concurrently with other xanthine medications. Use with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, in the elderly (especially males) and in neonates. In particular, great caution should be used in giving theophylline to patients with congestive heart failure. Frequently, such patients have markedly prolonged theophylline serum levels with theophylline persisting in serum for long periods following discontinuation of the drug. Individuals who are rapid metabolizers of theophylline, such as the young, smokers, and some non-smoking adults, may not be suitable candidates for once-daily dosing. These individuals will generally need to be dosed at 12 hour or sometimes 8 hour intervals. Such patients may exhibit symptoms of bronchospasm near the end of a dosing interval, or may have wider peak-to-trough differences than desired.

Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to the G.I. tract although gastrointestinal symptoms are more commonly centrally mediated and associated with serum drug concentrations over 20 mcg/ml.

Information for Patients: The physician should reinforce the importance of taking only the prescribed dose and time interval between doses. THEO-DUR tablets should not be chewed or crushed. When dosing THEO-DUR on a once daily (q24h) basis, tablets should be taken whole and not split. As with any controlled-release theophylline product, the patient should alert the physician if symptoms occur repeatedly, especially near the end of the dosing interval.

DRUG INTERACTIONS: Drug-Drug: Toxic synergism with ephedrine has been documented and may occur with some other sympathomimetic bronchodilators. In addition, the following drug interactions have been demonstrated:

Drug	Effect
Theophylline with lithium carbonate	Increased excretion of lithium carbonate
Theophylline with propranolol	Antagonism of propranolol effect
Theophylline with cimetidine	Increased theophylline blood levels
Theophylline with troleandomycin, erythromycin	Increased theophylline blood levels

Drug-Food: THEO-DUR 100 mg Sustained Action Tablets have not been adequately studied to determine whether their bioavailability is altered when given with food. Available data suggest that drug administration at the time of food ingestion may influence the absorption characteristics of theophylline controlled-release products resulting in serum values different from those found after administration in the fasting state.

A drug-food effect, if any, would likely have its greatest clinical significance when high theophylline serum levels are being maintained and/or when large single doses (greater than 13 mg/kg or 900 mg) of a controlled-release theophylline product are given.

THEO-DUR (200, 300, and 450 mg) Sustained Action Tablets: The rate and extent of absorption of theophylline from THEO-DUR 200 mg, 300 mg, and 450 mg tablets when administered fasting or immediately after a moderately high fat content breakfast is similar.

Drug-Laboratory Test Interactions: When plasma levels of theophylline are measured by spectrophotometric methods, coffee, tea, cola beverages, chocolate, and acetaminophen contribute falsely high values.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic potential, mutagenic potential, or the effect on fertility of xanthine compounds.

Pregnancy: Category C—Animal reproduction studies have not been conducted with theophylline. It is not known whether theophylline can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Xanthines should be given to a pregnant woman only if clearly needed.

Nursing Mothers: It has been reported that theophylline distributes readily into breast milk and may cause adverse effects in the infant. Caution must be used if prescribing xanthine to a mother who is nursing, taking into account the risk/benefit of this therapy.

Pediatric Use: Safety and effectiveness of THEO-DUR administered:

1. Every 24 hours in children under 12 years of age, have not been established
2. Every 12 hours in children under 6 years of age, have not been established

ADVERSE REACTIONS: The most consistent adverse reactions are usually due to overdose and are:

1. *Gastrointestinal:* nausea, vomiting, epigastric pain, hematemesis, diarrhea
2. *Central nervous system:* headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions
3. *Cardiovascular:* palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias
4. *Respiratory:* tachypnea
5. *Renal:* albuminuria, increased excretion of renal tubular and red blood cells, potentiation of diuretics.
6. *Other:* rash, hyperglycemia and inappropriate ADH syndrome.

OVERDOSEAGE: Management: If potential oral overdose is established and seizure has not occurred

- A. Induce vomiting.
 - B. Administer a cathartic (this is particularly important if sustained-release preparations have been taken).
 - C. Administer activated charcoal.
- If patient is having a seizure
- A. Establish an airway.
 - B. Administer oxygen.
 - C. Treat the seizure with intravenous diazepam, 0.1 to 0.3 mg/kg up to 10 mg.
 - D. Monitor vital signs, maintain blood pressure and provide adequate hydration.

Post Seizure Care:

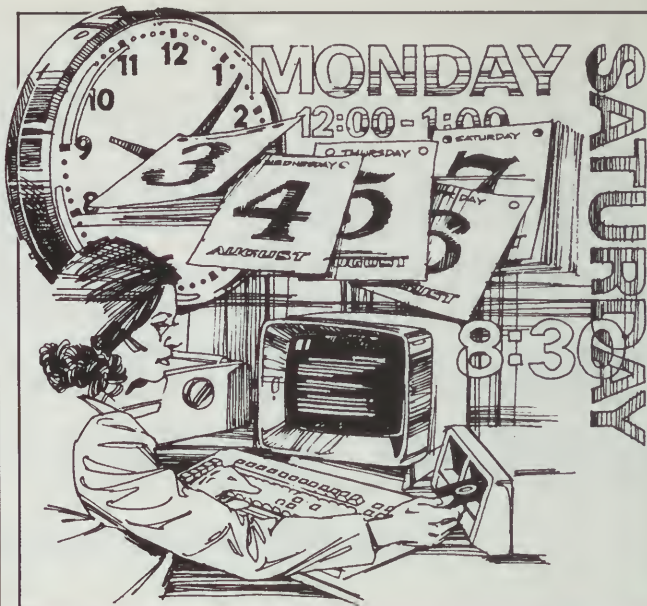
- A. Maintain airway and oxygenation.
- B. If a result of oral medication, follow above recommendations to prevent absorption of the drug, but intubation and lavage will have to be performed instead of inducing emesis, and the cathartic and charcoal will need to be introduced via a large bore gastric lavage tube.
- C. Continue to provide full supportive care and adequate hydration while waiting for drug to be metabolized. In general, the drug is metabolized sufficiently rapid so as not to warrant consideration of dialysis, however, if serum levels exceed 50 mcg/ml charcoal hemoperfusion may be indicated.

CAUTION: Federal law prohibits dispensing without prescription. For full prescribing information, see package insert. Revised 6/87

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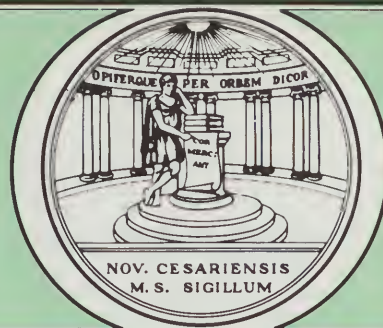
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MEMBERSHIP NEWSLETTER



THE MEDICAL SOCIETY OF NEW JERSEY

VOLUME 56

BLUE CROSS AND BLUE SHIELD Participation

Q. What does participation mean?

A. Participation means that a physician has signed an agreement with Blue Cross and Blue Shield of New Jersey (BCBSNJ), and has agreed to accept BCBSNJ payment as payment-in-full for covered services rendered to subscribers under the following circumstances:

- For patients who are covered under fixed fee schedules, (500 series, 750 series, 14/20 series) and qualify for service benefits by meeting certain income requirements. For example, in order for BCBSNJ payment to be considered payment-in-full under the 14/20 series program, the subscriber's gross annual income from all sources would have to be \$14,000 or less for a single, unmarried subscriber, \$20,000 for all other situations. (Income levels for the 500 Series are \$6,000 single and unmarried, \$8,500 for all others. Similarly, 750 Series income levels are \$7,500 and \$12,000). It is the subscriber's responsibility to notify the physician that he/she is under income, and must provide proof of income if requested by the physician.
- For patients who are covered under the paid-in-full reasonable and customary (R & C) program (P.A.C.E., MEDALLION, UCR coverages), regardless of income.

Q. What are the advantages of participation?

A. BCBSNJ pays participating physicians directly for services rendered (except when patients pay you or for Medicare supplementary payments when you do not take assignment). Also, many BCBSNJ patients have major medical contracts which can pay participating physicians supplemental amounts directly after fixed fee payments are made. By receiving direct reimbursement, participating physicians enjoy reduced collection and billing expenses overall. BCBSNJ also promotes the use of participating physicians to its subscribers. It publishes a "Who's Blue" book for its large group customers, and provides the names of participating physicians to subscribers who call a toll-free referral number. BCBSNJ also works directly with its large group customers to advise them of participating physicians in the area where their members live and work. Patients covered by BCBSNJ's new MEDALLION

coverage are especially likely to use participating physicians.

Q. What are the disadvantages of participation?

A. Depending on your fees, BCBSNJ's reasonable and customary allowances may not, in some cases, equal your charge. Yet, as a participating physician, you would have to accept the R & C allowance as payment-in-full. With fee schedule contracts, if a patient proves to you that he/she is "under income," you would have to accept BCBSNJ's fixed fee payment as payment-in-full. While this situation occurs infrequently, the write-off on a case can be significant.

Q. Many patients are still covered, though, by 14/20 Series and other fixed fee contracts. Does BCBSNJ continue to sell these contracts?

A. BCBSNJ no longer sells the fixed fee contracts to its group customers. It is expected that all fixed fee contracts for existing group and individual subscribers will be phased out by the early 1990s, to be replaced with coverages like P.A.C.E. and MEDALLION.

Q. How are fee allowances determined for the reasonable and customary (R & C) program (P.A.C.E., MEDALLION coverages)?

A. BCBSNJ reviews actual charges from claim forms received throughout the year. Each CPT-4 procedure code is reviewed for charges submitted by each physician specialty within three geographic areas of New Jersey, which generally correspond to southern, central, and northern New Jersey. Maximum R & C allowances are determined based upon these charge data. There are no individual physician profiles.

Q. If I become participating and later want to resign, what must I do, and when will my resignation be effective?

A. A physician may cancel the participating agreement by giving BCBSNJ 30 days written notice. The participating agreement will still apply, however, to any BCBSNJ subscriber contract that currently is in force until the end of the subscriber's contract year. Since the subscription contracts are renewed every 12 months and subscribers have different effective dates, it may take one year before the resignation is fully in effect.

Q. Must I sign a separate agreement for MEDALLION?

A. No. MEDALLION is a traditional health insurance program that covers a variety of services such

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the Department of Insurance to perform preadmission certification.

They are the only legally recognized organizations in New Jersey and their addresses are supplied for your assistance:

The Peer Review Organization of New Jersey, Inc.

Central Division
Brier Hill Court, Building J
East Brunswick, New Jersey 08816

The Peer Review Organization of New Jersey, Inc.

Southern Division
1040 Kings Highway N., #500
Cherry Hill, New Jersey 08034

AXIOM PRO-AXIOM REVIEW

33 Bleeker Street
Millburn, New Jersey 07041

North Jersey Physicians Review

120 Littleton Road
Parsippany, New Jersey 07054

***Prudential Insurance Company**

P.O. Box #6500
Millville, New Jersey 08332

***Provident Life and Accident**

123 Franklin Corner Road
Lawrenceville, New Jersey 08648

***Home Life Insurance Company**

600 Alexander Road
Princeton, New Jersey 08543

Passaic Valley PSRO

573 Valley Road
Wayne, New Jersey 07470

North Jersey Physicians Review

299 Market Street
Saddle Brook, New Jersey 07662

***New Jersey Blue Cross**

33 Washington Street
Newark, New Jersey 07102

***Connecticut Mutual Life**

3 ADP Boulevard
Roseland, New Jersey 07068

as office visits, unlimited lab, x-ray, and well-child care. Payments are made via the R & C allowances previously discussed.

Q. How many physicians in New Jersey participate?

A. Blue Cross and Blue Shield currently has participating agreements with 9,218 M.D.s in New Jersey.

Q. Do physicians have input into BCBSNJ decisions about the kinds of medical-surgical services that are eligible for reimbursement? How about new procedures and technologies?

A. BCBSNJ several years ago formed the Multi-Specialty Advisory Committee, commonly referred to as MAC. The MAC is comprised of physician representatives nominated by specialty societies within New Jersey. The MAC reviews and considers medical-surgical issues and procedures, and makes recommendations to BCBSNJ's Professional Advisory Committee, which reports directly to the BCBSNJ Board of Directors.

CARRIER FOUNDATION

Pharmacological Research on Anti-Anxiety Agents

The research department at the Carrier Foundation, Belle Mead, is conducting a study to evaluate the effects of a concurrent administration schedule for replacing benzodiazepine use with buspirone, a nonaddictive anti-anxiety compound. Individuals who have been taking either alprazolam (Xanax®), diazepam (Valium®), or lorazepam (Ativan®), for the treatment of anxiety for 3 to 36 months are needed to participate in this study. Eligible individuals will receive a physical examination, laboratory tests, medication, and weekly assessment sessions, free of charge. Confidentiality will be strictly maintained. Bradley D. Evans, M.D., director of addiction recovery services, and Helen M. Pet-

tinati, Ph.D., director of research, will supervise the study. For more information about this program or to refer eligible individuals, contact Hugh Smith, at 201-874-4000, extension 4396.

INTERNATIONAL TELEPHONE Disease Control

A disposable telephone is being offered in the patient's admission kit as a measure to control cross infections in hospitalized patients, by International Telephone Inc. For further information, call 201/387-7767.

CARRIER FOUNDATION

Clues and Warning Signs of Suicide in the Elderly

Verbal Clues

- I'm going to kill myself.
- I'm going to commit suicide.
- I'm going to end it all.
- I want to end it all.
- I just want out.
- You would be better off without me.

Behavioral Clues

- Donating body to a medical school.
- Purchasing a gun.
- Stockpiling pills.
- Putting personal and business affairs in order.
- Making or changing a will.
- Taking out insurance or changing beneficiaries.
- Making funeral plans.
- Giving away money and/or possessions.
- Changes in behavior, especially episodes of screaming or hitting, throwing things, or failure to get along with family, friends, or peers.
- Suspicious behavior, for example, going out at

odd times of the day or night, waving or kissing goodbye (if not characteristic).

- Sudden interest or disinterest in church and religion.
- Scheduling of appointment with doctor for no apparent physical cause or very shortly after the last visit to the doctor.
- Loss of physical skills, general confusion, or loss of understanding, judgment, or memory.

Situational Clues

- Recent move.
- Death of a spouse.
- Diagnosis of terminal illness.
- Flare-up with relative or close friend.

Symptoms of Late-Life Depression

- Change in sleep patterns, particularly insomnia.
- Change in eating patterns, especially loss of appetite.
- Weight loss.
- Extreme fatigue.
- Increased concern with bodily functions (e.g., frequent complaints of constipation, loose bowels, aches and pains, dizziness, increased heart rate).
- Change in mood, particularly if listless, apathetic, angry, hostile, nervous, irritable, depressed, sad, or withdrawn.
- Expression of fears and anxieties, without any reason.

- Low self-esteem or self-concept, feelings of worthlessness, pessimism.

Warning Signs of Alcoholism in the Elderly

- Increase in amount of alcohol or number of alcoholic drinks taken.
- Behavioral manifestations of anger, hostility, belligerence.
- Odor of alcohol on breath, especially in the morning.
- Flushed face.
- Trembling and the 'shakes'.
- Blackout periods.
- Hangovers.
- Alcoholic hepatitis, cirrhosis, chronic gastritis.
- Drinking in spite of medical admonitions against alcohol use.
- Problems with family members, friends, or relatives.
- Inability to do simple tasks, confusion, slurred speech, or retarded motor skills.
- Inability to conduct normal everyday tasks without drinking.
- Financial problems related to alcohol use.

FINI

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CLARK MARTIN*

Struggling with Auto Insurance; PAs Raise Fuss

STRUGGLING WITH AUTO INSURANCE

"But in this world nothing can be said to be certain, except death and taxes."—Benjamin Franklin

If Ben Franklin were living in New Jersey today, he'd probably add "high auto insurance premiums" to his short list of life's certainties.

Will premiums ever drop? For years, the Legislature has struggled to reduce premiums, assure that drivers have adequate coverage, and guarantee injured parties the right to sue for pain and suffering. Apparently, the goals are mutually exclusive.

Nevertheless, the effort goes on. Stung by a new state-mandated insurance surcharge averaging \$100, legislative leaders announced that both houses will go into "continuous session" this summer to forge a solution.

Obviously, medicine has a stake in this. One proposal under consideration is the repeal of Personal Injury Protection coverage (PIP), the only true "no-fault" feature of New Jersey's no-fault auto insurance system. PIP pays an injured driver's hospital and physician bills regardless of who caused the accident. If PIP is repealed, these expenses would have to be covered by an employee's health insurance—an idea strongly opposed by the business lobbies—or would be left largely unpaid until lawsuits are settled.

Also under consideration (for the umpteenth time) is enactment of a medical fee schedule, which might lower the amount of premium attributable to PIP by a minuscule amount. The critical issue here is whether

a fee schedule feature in the law would permit balance billing.

These medical issues have been overshadowed in the media by the endless debate over the lawsuit threshold, meaning driver A can sue driver B for pain and suffering after driver A's medical bills exceed a given amount.

Governor Kean and a number of Assembly leaders are calling for a "verbal threshold," meaning that driver A can sue driver B only after driver A can prove he has suffered a permanent, serious injury. The theory is that a verbal threshold would produce fewer lawsuits, so premiums would at least stabilize, if not fall.

A "verbal threshold" was passed in the Assembly in the last session, but was voted down both by Republicans and Democrats in the Senate.

The Society has taken no position on the lawsuit threshold, and for good reason. It is not a medical issue. When and if a patient can sue somebody else for pain and suffering is not our concern; in contrast, PIP and the fee schedule are legitimate medical issues.

Nevertheless, as New Jersey residents and drivers, physicians are as entitled as anyone else to have an opinion about the lawsuit threshold. Our only request is this: If you communicate with a legislator about this aspect of auto insurance, please make it clear that you are expressing a personal opinion and not a Medical Society position.

PAs RAISE FUSS

Stunned by the Assembly's passage of a bill which would block their effort to force the Board of Medical Examiners to license them, physician assistants have mounted a vigorous public relations campaign against the bill.

A-1591, which passed in the lower house in February, would prohibit any state agency from licensing or otherwise allowing a category of health care professionals to practice unless first authorized by statute. PA licensing bills have failed in the Legislature numerous times in the past ten years.

Striking at the bill, the State Society of Physician Assistants has coupled visits to the editorial boards of major daily and weekly newspapers with a vigorous letters-to-the-editor writing campaign.

Numerous pro-PA editorials and articles have resulted. Their recurring theme is that New Jersey is an "odd duck" because it is the only state that does not permit PAs to practice, passage of A-1591 would prevent PAs from ever working here, and PAs would provide accessible, high-quality, cost-effective health care to all citizens.

Of these arguments, the fact that New Jersey stands alone does attract attention and arouse curiosity. But the claim that passage of A-1591 would forever prevent PAs from working here bears closer examination.

Absent enactment of A-1591, it is still doubtful that the Medical Examiners would license PAs by regulation. The Board has indicated that current law does not give it the authority to create licenses. That being so, only the Legislature can decide the question—which is precisely the point of A-1591.

*Mr. Martin is MSNJ's legislative consultant.

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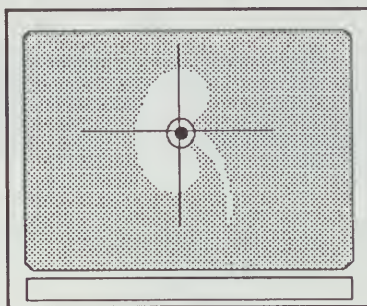
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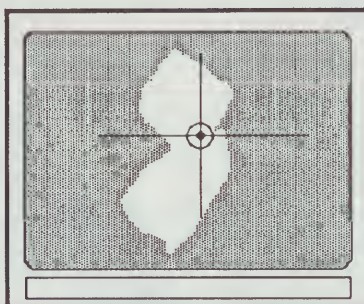
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Medical Errors

***Retesting Physicians for Relicensure;
Judges Support Changes in Malpractice
Dispute Resolution System; AIDS
Malpractice Verdict***

RETESTING PHYSICIANS FOR RELICENSURE

Acting at the expressed direction of Governor Mario Cuomo, an advisory committee of the New York State Board of Regents has issued a report calling for reexamination of all physicians every nine years as a prerequisite for licensure renewal. The Board now must decide whether to impose the regulations. If it does, New York will become the first state to regularly recheck all of its physicians.

Physicians could seek relicensure in one of several ways: take an examination, undergo peer review, have their patient records evaluated, or obtain recertification from a specialty board.

There are 50,000 physicians licensed in New York. The proposed program, favored by the governor, would be designed to assure that physicians stay current educationally. Those found deficient would have to take steps to correct shortcomings or lose their licenses.

Indications are that the proposal stands a good chance of being adopted. Said the Board in its report: "The goal of the recredentialing process is the prevention of medical errors." The American Medical Association has expressed some reservations. (*Medical Liability Monitor*, March 29, 1988, Vol. 13, Number 3)

JUDGES SUPPORT CHANGES IN MALPRACTICE DISPUTE RESOLUTION SYSTEM

Advocates of professional liability tort reform may find unexpected support from an untapped source—American judges. In the first national study of judicial views on the handling of medical malpractice, commissioned in 1987 by the American College of Obstetri-

cians and Gynecologists, some rather surprising findings emerged:

- Of federal and state judges, 84 percent favors use of court-appointed impartial expert witnesses. (And, 84 percent favors use of an impartial witness agreed upon by both parties; 58 percent favors use of a court-appointed expert witness selected from a predetermined list.)

- The public would be better served if incentives were provided to encourage early settlement of cases, believes 84 percent.

- Changes in collateral source rules to subtract amount received from health insurance, worker's compensation, and other sources, from malpractice awards, are endorsed by 55 percent.

- Periodic payments of awards above certain amounts are supported by 49 percent.

A smaller percentage (44 percent) favors the use of arbitration as a means of resolving malpractice suits.

While the 338 randomly selected state and federal judges voiced quite substantial support for changes that would make the present malpractice claims disposition process fairer and more efficient, the majority of these respondents opposed changes that would eliminate any of the elements in the present civil justice system. For example: 53 percent opposes caps on noneconomic awards; 78 percent opposes a shortened statute of limitations for minors; 65 percent opposes elimination of punitive damages; and 75 percent opposes changing the burden of proof to clear and convincing.

The telephone survey, conducted by Penn & Schoen Associates, Inc., New York City, from August 5 to 19, 1987, was reported in the March 1987 issue of *Obstetrics and Gynecology*. An accompanying editorial, written by Keith White, M.D., and Kenneth Heland, J.D., of the ACOG staff, called attention to a 1987 Harris Poll indicating substantial public support for similar changes favored by judges in the present malpractice system.

"We can see broad agreement in several segments of society that something should be done to improve the legal system under which we operate," the authors said.

Although White and Heland said it was encouraging to see such support, "Our enthusiasm for change has to be tempered by what appears to be possible. Our efforts should be directed toward improving the efficiency and fairness of the system for all participants. If efforts to improve the system are perceived as an attempt merely to get the physicians "off the hook," they probably will not succeed. But if we genuinely try to change the system for the general good, we will find allies in the judiciary and among the public at large." (*Medical Liability Monitor*, March 29, 1988, Vol. 13, Number 3)

AIDS MALPRACTICE VERDICT

A \$750,000 judgment handed down in the nation's first AIDS-based malpractice case may soon be appealed by the Cambridge, Massachusetts internist who

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are Director of the Department, and Director of Special Projects.

lost the case in Middlesex County superior court.

The jury's message was that primary care physicians will be in "deep trouble" if they "resort to a psychiatric diagnosis before performing diagnostic testing to confirm or rule out physical cause," said the plaintiff's attorney.

In January, the jury found against the internist who works for the Harvard Community Health Plan, a large HMO, for failing, in 1985, to diagnose *Pneumocystis carinii* pneumonia in a woman found to have antibodies to human immunodeficiency virus. In her lawsuit, the plaintiff, a former insurance company claims supervisor, maintained that the physician's missed diagnosis had led to permanent pulmonary damage.

The defendant treated the plaintiff between May and September of that year for chest pains, shortness of breath, and a persistent dry cough—which he attributed to bronchitis and asthma. In August, the 32 year-old woman learned at a blood bank that she had antibodies to HIV. The plaintiff told the defendant about the test result, but on the basis of a clear chest x-ray and physical examination, he stuck by his original diagnosis. He prescribed antibiotics, cough medicine, and a bronchial inhaler.

The plaintiff's symptoms persisted, and she testified that the defendant said anxiety about the HIV test result was making her asthma worse.

In late September, the defendant referred her to a pulmonary consultant for bronchoscopy. He said he had been reluctant to order the test, which several physician witnesses testified is definitive, for PCP, because "it has a number of risks."

As it happened, the plaintiff became so ill before her scheduled appointment with the pulmonologist that she went to the emergency rooms at Mount Auburn Hospital and Boston City Hospital. At Boston City Hospital, the pneumonia diagnosis was made on the basis of a sputum culture and a bronchial wash, and she was admitted and treated with trimethoprim-sulfamethoxazole for eight weeks.

Since being discharged, the plaintiff testified, she has been unable to work or to carry out her normal household duties as the mother of two boys, aged 7 and 13.

The jury awarded the plaintiff \$500,000 for past and future medical expenses, pain, suffering, and damages, plus another \$250,000 to her sons.

Extensive and often contradictory testimony from ten physicians centered on what was known about AIDS in 1985 and what constituted standards of care in the community. The witnesses raised a number of questions about perceptions of risk, physicians' reluctance to panic their patients, and the use of diagnostic tests in an HMO setting.

The plaintiff believes she contracted AIDS from a former lover who used intravenous (IV) drugs. In 1985, the few AIDS patients treated by Harvard Community Health Plan physicians primarily were gay men, according to a plan spokesman. Female sexual partners of male IV drug abusers did not have the high profile they have today and "at that time, the plaintiff was not

considered to be in one of the high-risk groups," he said.

The plaintiff's testimony attorney argued that heterosexual transmission was well known in 1985 and that the plaintiff should have been seen as being at high risk because three years earlier she had contracted rectal gonorrhea from the same IV drug-using partner. That episode was noted in her chart by the nurse-practitioner who treated her. The defendant did not re-examine her sexual history when he learned of her positive HIV test.

The plaintiff's route of infection was clinically irrelevant, according to a Belmont internist who testified on the defendant's behalf. "The physicians who took care of her knew that she carried the AIDS virus. The question was whether she was sick enough to require bronchoscopy before she came down with a florid pneumonia."

The defendant's internist expert said it would be unreasonable to perform an invasive test like bronchoscopy on every patient who had the plaintiff's symptoms plus a history of asthma and heavy smoking, even if they also were HIV antibody-positive. Harvard Community Health Plan's spokesman concurred, saying, "The defendant was an internist in a setting where he saw a large number of people with symptoms that were similar to the plaintiff's, but that obviously were not related to AIDS or pneumocystis."

The plaintiff's attorney contends that the defendant could have made the diagnosis with arterial blood gas testing or a gallium scan. He also argued during the trial that the HMO guidelines for assessing physician performance pressured physicians "not to let hysteria over malpractice cause them to perform unnecessary, expensive tests."

The attorney also entered as evidence several pre-1985 articles from *The New England Journal of Medicine* and the *Journal of the American Medical Association* which recommended that PCP be "immediately ruled out or confirmed" in patients with "known or suspected AIDS."

The Belmont internist recalls that in 1985, the CDC estimated that perhaps only 10 to 20 percent of HIV antibody-positive people would actually develop AIDS. "As primary physicians, we were being told not to alarm these patients," he said.

Moreover, he thinks the defendant's diagnosis made sense because the plaintiff had two normal chest x-rays and at the time physicians did not know that "about 5 percent of those with pneumocystis have clear chest x-rays."

"The diagnosis in this case was not simple," he emphasized. In his opinion, the defendant acted according to the "medical standards of the average internist in practice in this area."

"Times have changed since 1985. Today a patient like the plaintiff would be worked up quickly. Most physicians know they have got to look for opportunistic infections aggressively when they see an HIV-positive patient," claimed the Belmont internist. (Patricia Thomas, *Medical World News*, March 28, 1988)



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C I B A

References: 1. Data on file, CIBA Pharmaceutical Company. 2. Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. 3. Skoutakis VA, Carter CA, Acchiardo SR: Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

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INDICATIONS AND USAGE

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1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.
2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure; hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.
3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS

Hyperkalemia (See OVERDOSAGE).

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or furosemide), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS

General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients

Physicians should consider reminding the patient of the following:

- To take each dose without crushing, chewing, or sucking the tablets.
- To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.
- To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.
- To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions

Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 mEq of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

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Complaints and Commendations

PALMA E. FORMICA, M.D.*

Letters to the president of the Medical Society of New Jersey are the focus of this first essay.

As president, I have received a flood of letters in just the past few weeks. I would like to share two of them with you.

The first letter is from a writer who was so frustrated she wrote a two-page, single-spaced essay voicing complaints about her perceptions of physician indifference toward patients. It was not the tone of the usual crank letter: her concerns are legitimate, and I promised to bring them to the attention of our membership.

What was her complaint? Waiting to see doctors:

An appointment card carries both the doctor's and the patient's name. Yet too many doctors—women as well as men—see that appointment as binding only the patient. The moral contract implied by the appointment is violated repeatedly by too many doctors. It's a way for doctors to keep their options open while closing out the patient's options. The practice shows a contemptuous disregard for the value of the patient's time.

In these days of really serious problems facing the profession, why should I even consider such a triviality? Practice management consultants consider this

to be the number one complaint among patients. Even one of our legislators voiced the same complaints.

Tom Peters in *Search for Excellence* points out that the most successful companies in America concentrate on customer satisfaction; our "customers" are our patients.

We worry about our professional image and the lack of respect the public shows us. Isn't it time we look at some of those criticisms to see how we can remedy this perception. Public relations begins in our offices.

Who among us is not guilty of keeping patients waiting at some time or another. When it is the routine and not the exception, then we have a problem. Do we call our reception area the "waiting room" even when most of us work by appointments? Are not delays to be expected? Is this not the modus operandi of physicians?

It has been said, "A full waiting room means the doctor is either good or cheap." Do we delude ourselves into thinking that we are so good and so busy that our patients do not mind waiting? Studies have shown that most people will not complain about a 20-minute wait, but anger and frustration increase as each minute slips away. Keeping people waiting, when the wait can be avoided, is discourteous and bad business, to say the least. In these days of increased competition and urgicenters advertising "no waiting," indications are that people hate to wait.

I am certain that none of us sets out to keep people waiting, but delays can happen. Emergencies and unscheduled interruptions are part of a physician's day, and as the caregiver, we too become frustrated and upset when our schedules run overtime. However, there are some tips for keeping those delays to a minimum. But more about that next time.

The second letter I received recently brings to the attention of the Medical Society of New Jersey, the outstanding humanitarian act of Dr. Paul Reilly of Caldwell. When his patient had complications from cardiac surgery and had to return to Wisconsin, Dr. Reilly cancelled appointments and without recompense accompanied his patient to Wisconsin.

Dr. Reilly is commended by the Medical Society of New Jersey as an exemplary physician who bears witness to the dedication of members of the profession.

I am certain there are many such acts of selfless humanitarianism performed by physicians. I invite the members of the Society to send other examples, so we may give recognition to the nominated physicians. Isn't it time we honor those among us who serve our patients and the profession in an outstanding way?

*Correspondence may be addressed to Dr. Palma Formica, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648.



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WARNINGS: FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS.

BACTRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. Clinical signs, such as rash, sore throat, fever, arthralgia, cough, shortness of breath, pallor, purpura or jaundice, may be early indications of serious reactions. In rare instances a skin rash may be followed by more severe reactions, such as Stevens-Johnson syndrome, toxic epidermal necrolysis, hepatic necrosis or serious blood disorder. Perform complete blood counts frequently. **BACTRIM SHOULD NOT BE USED IN THE TREATMENT OF STREPTOCOCCAL PHARYNGITIS.** Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have a greater incidence of bacteriologic failure when treated with Bactrim than with penicillin.

PRECAUTIONS: General: Give with caution to patients with impaired renal or hepatic function, possible folate deficiency (e.g., elderly, chronic alcoholics, patients on anticonvulsants, with malabsorption syndrome, or in malnutrition states) and severe allergies or bronchial asthma. In glucose-6-phosphate dehydrogenase deficient individuals, hemolysis may occur, frequently dose-related.

Use in the Elderly: May be increased risk of severe adverse reactions in elderly, particularly with complicating conditions, e.g., impaired kidney and/or liver function, concomitant use of other drugs. Severe skin reactions, generalized bone marrow suppression (see WARNINGS and ADVERSE REACTIONS) or a specific decrease in platelets (with or without purpura) are most frequently reported severe adverse reactions in elderly. In those concurrently receiving certain diuretics, primarily thiazides, increased incidence of thrombocytopenia with purpura reported. Make appropriate dosage adjustments for patients with impaired kidney function (see DOSAGE AND ADMINISTRATION).

Use in the Treatment of Pneumocystis Carinii Pneumonia in Patients with Acquired Immunodeficiency Syndrome (AIDS): AIDS patients may not tolerate or respond to Bactrim in same manner as non-AIDS patients. Incidence of side effects, particularly rash, fever, leukopenia, elevated aminotransferase (transaminase) values, with Bactrim in AIDS patients treated for *Pneumocystis carinii* pneumonia reported to be greatly increased compared with incidence normally associated with Bactrim in non-AIDS patients.

Information for Patients: Instruct patients to maintain adequate fluid intake to prevent crystalluria and stone formation.

Laboratory Tests: Perform complete blood counts frequently; if a significant reduction in the count of any formed blood element is noted, discontinue Bactrim. Perform urinalyses with careful microscopic examination and renal function tests during therapy, particularly for patients with impaired renal function.

Drug Interactions: In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombocytopenia with purpura has been reported. Bactrim may prolong the prothrombin time in patients who are receiving the anticoagulant warfarin. Keep this in mind when Bactrim is used in patients already on anticoagulant therapy and reassess coagulation time. Bactrim may inhibit the hepatic metabolism of phenytoin. Given at a common clinical dosage, it increased the phenytoin half-life by 39% and decreased the phenytoin metabolic clearance rate by 27%. When giving these drugs concurrently, be alert for possible excessive phenytoin effect. Sulfonamides can displace methotrexate from plasma protein binding sites, thus increasing free methotrexate concentrations.

Drug/Laboratory Test Interactions: Bactrim, specifically the trimethoprim component, can interfere with a serum methotrexate assay as determined by the competitive binding protein technique (CBPA) when a bacterial dihydrofolate reductase is used as the binding protein. No interference occurs if methotrexate is measured by a radioimmunoassay (RIA). The presence of trimethoprim and sulfamethoxazole may also interfere with the Jaffe alkaline picrate reaction assay for creatinine, resulting in overestimations of about 10% in the range of normal values.

Carcinogenesis, Mutagenesis, Impairment of Fertility: **Carcinogenesis:** Long-term studies in animals to evaluate carcinogenic potential not conducted with Bactrim. **Mutagenesis:** Bacterial mutagenic studies not performed with sulfamethoxazole and trimethoprim in combination. Trimethoprim demonstrated to be nonmutagenic in the Ames assay. No chromosomal damage observed in human leukocytes *in vitro* with sulfamethoxazole and trimethoprim alone or in combination; concentrations used exceeded blood levels of these compounds following therapy with Bactrim. Observations of leukocytes obtained from patients treated with Bactrim revealed no chromosomal abnormalities. **Impairment of Fertility:** No adverse effects on fertility or general reproductive performance observed in rats given oral dosages as high as 70 mg/kg/day trimethoprim plus 350 mg/kg/day sulfamethoxazole.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Trimethoprim and sulfamethoxazole may interfere with folate acid metabolism; use during pregnancy only if potential benefit justifies potential risk to fetus. **Nonteratogenic Effects:** See CONTRAINDICATIONS section.

Nursing Mothers: See CONTRAINDICATIONS section.

Pediatric Use: Not recommended for infants under two months (see INDICATIONS and CONTRAINDICATIONS sections).

ADVERSE REACTIONS: Most common are gastrointestinal disturbances (nausea, vomiting, anorexia) and allergic skin reactions (such as rash and urticaria). **FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS (SEE WARNINGS SECTION).**

Hematologic: Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, neutropenia, hemolytic anemia, megaloblastic anemia, hypoprothrombinemia, eosinophilia, methemoglobinemia, allergic reactions: Stevens-Johnson syndrome, toxic epidermal necrolysis, anaphylaxis, allergic myocarditis, erythema multiforme, exfoliative dermatitis, angioedema, drug fever, chills, Henoch-Schoenlein purpura, serum sickness-like syndrome, generalized allergic reactions, generalized skin eruptions, photosensitivity, conjunctival and scleral injection, pruritus, urticaria and rash, Periarteritis nodosa and systemic lupus erythematosus have been reported. **Gastrointestinal:** Hepatitis (including cholestatic jaundice and hepatic necrosis), elevation of serum transaminase and bilirubin, pseudomembranous enterocolitis, pancreatitis, stomatitis, glossitis, nausea, emesis, abdominal pain, diarrhea, anorexia. **Genitourinary:** Renal failure, interstitial nephritis, BUN and serum creatinine elevation, toxic nephrosis with oliguria and anuria, crystalluria. **Neurologic:** Aseptic meningitis, convulsions, peripheral neuritis, ataxia, vertigo, tinnitus, headache. **Psychiatric:** Hallucinations, depression, apathy, nervousness. **Endocrine:** Sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents; cross-sensitivity may exist. Diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. **Respiratory:** Pulmonary infiltrates. **Musculoskeletal:** Arthralgia, myalgia. **Miscellaneous:** Weakness, fatigue, insomnia.

OSAGE AND ADMINISTRATION: Not recommended for use in infants less than two months of age. **URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE DTITIS MEDIA IN CHILDREN:** Usual adult dosage for urinary tract infections is one DS tablet, two tablets or four teaspoonfuls (20 ml) b.i.d. for 10 to 14 days. Use identical daily dosage for 5 days for shigellosis. **Recommended dosage for children** with urinary tract infections or acute otitis media is 8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses every 12 hours for 10 days. Use identical daily dosage for 5 days for shigellosis. **Renal Impaired:** Creatinine clearance above 30 ml/min, give usual dosage; 15-30 ml/min, give one-half the usual regimen; below 15 ml/min, use not recommended.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS: Usual adult dosage is one DS tablet, two tablets or four teasp (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONIA: Recommended dosage is 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

HOW SUPPLIED: DS (double strength) Tablets (160 mg trimethoprim and 800 mg sulfamethoxazole)—bottles of 100, 250 and 500; Tel-E-Dose[®] packages of 100; Prescription Paks of 20. Tablets (80 mg trimethoprim and 400 mg sulfamethoxazole)—bottles of 100 and 500; Tel-E-Dose[®] packages of 100; Prescription Paks of 40. **Pediatric Suspension** (40 mg trimethoprim and 200 mg sulfamethoxazole per teasp.)—bottles of 100 ml and 16 oz (1 pint). **Suspension** (40 mg trimethoprim and 200 mg sulfamethoxazole per teasp.)—bottles of 16 oz (1 pint).

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HOWARD D. SLOBODIEN, M.D.

**Hospital Peer Reviewing;
Transactions; NEW JERSEY MEDICINE**



Most of you are aware of the continuing pressure on the medical profession to "clean up its act," to get rid of the impaired, incompetent, or dangerous physician. These terms are not interchangeable, but tend to be viewed that way by the media. Although there no longer is the same "conspiracy of silence" as in the past, certainly some physicians have been reluctant to blow the whistle on their colleagues. Of the several reasons for this reluctance, none has been more important than the threat of suit, sometimes with the additional threat of punitive damages, that can have a chilling effect on the best-intentioned efforts of those dedicated to maintaining the high quality of medical care.

And, now, the chill threatens to become a deep freeze. On May 16, 1988, the United States Supreme Court affirmed, 8-0, that physicians doing hospital peer review can be sued under antitrust laws and can be subject to large punitive awards, not covered by insurance. What are we to do? Can we be expected to police ourselves properly, as many of us have been doing, without new concerns about our own present and future welfare and that of our families?

The situation reminds me of the story of the relief pitcher being advised by the manager "not to walk him, but not to give him anything to hit." The pitcher says to himself, "I might as well eat the ball." And that is where we find ourselves: in the position of trying to swallow this unpalatable pill given us by the courts.

Stay tuned. Much has yet to be said on this subject; by the time you read this, we may well be at an entirely different level of understanding

This issue of *NEW JERSEY MEDICINE* contains the transactions of the House of Delegates in the 222nd year of the Medical Society of New Jersey. It records the accomplishments of the past year, some of the frustrations encountered, and a fair idea of the roads we must travel in order to keep faith with our patients as we continue to render quality medical care. Many thanks are due to Dr. Harry Carnes, immediate past-president, for an outstanding job. Our best wishes go to Dr. Palma Formica, our new president, on whose capable shoulders ride so many hopes for the coming year.

This also is the first issue in 15 years without the strong and steady hand of Dr. Arthur Krosnick at the helm. During his stewardship, *NEW JERSEY MEDICINE* developed a national reputation and received awards for excellence, including the recent first prize in the Sandoz competition. We all are indebted to Dr. Krosnick and wish him well in all his endeavors; we shall miss him.

We can help to repay our debt to him by ensuring the continuance of his standards. Our staff, the MSNJ staff, the Publications Committee, and the Editorial Board will maintain the level of their contributions. Can we count on you, Loyal Reader? We welcome your correspondence, especially manuscripts for publication. But, also, we look forward to your comments on all aspects of the journal, its format, and its content, so that we can hold, and perhaps exceed, our present high standards for *NEW JERSEY MEDICINE*.

Onward and upward. Excelsior!

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The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable

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1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

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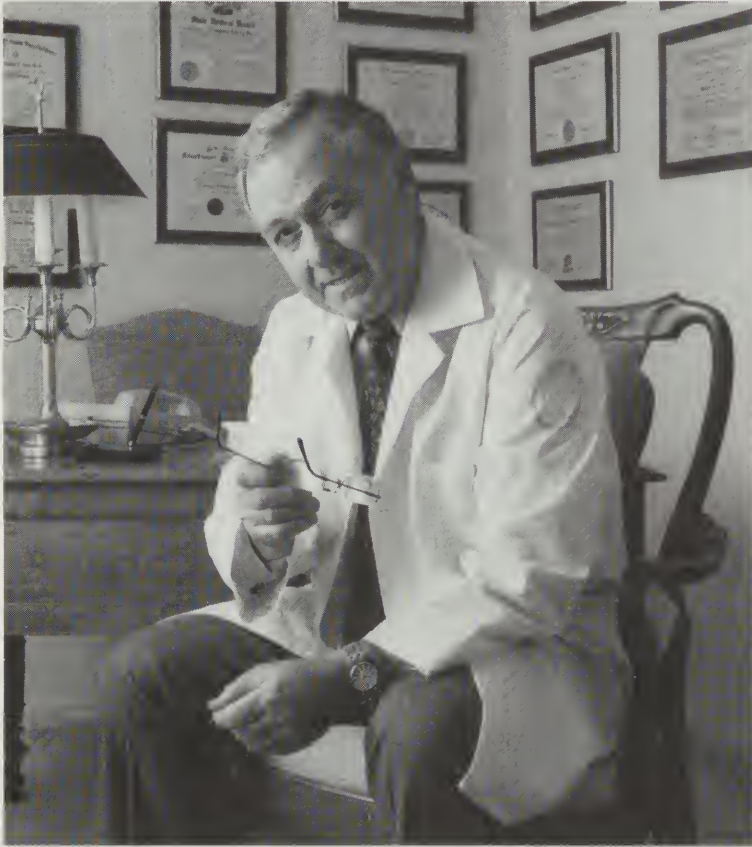
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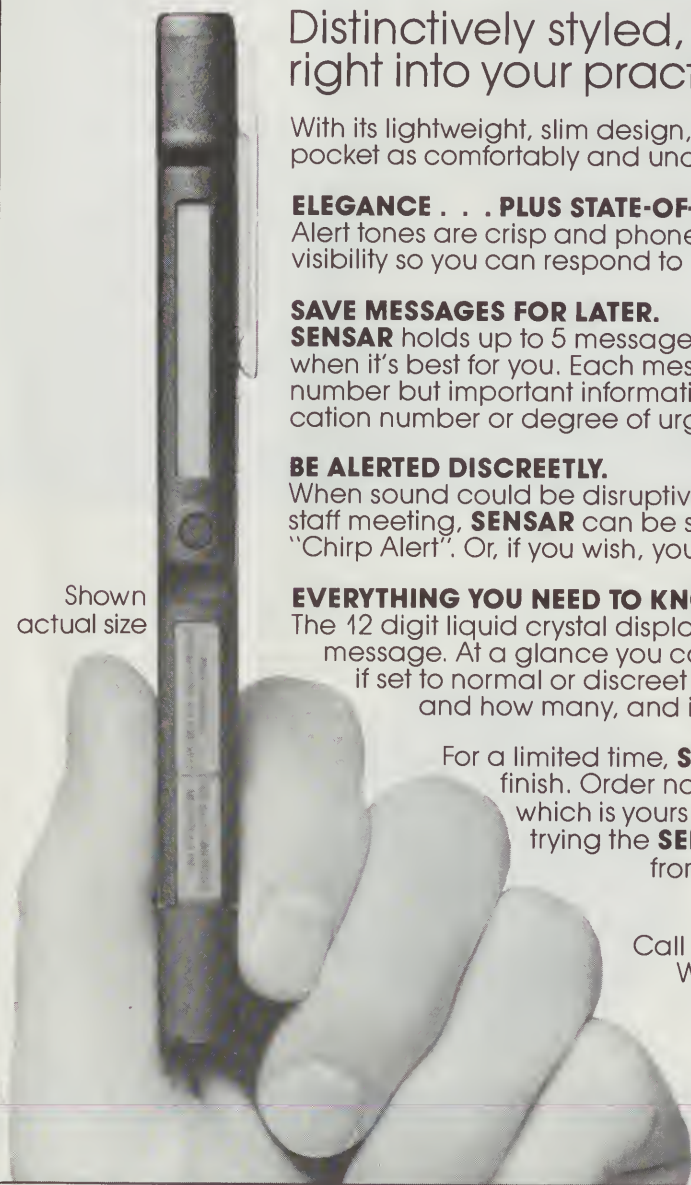
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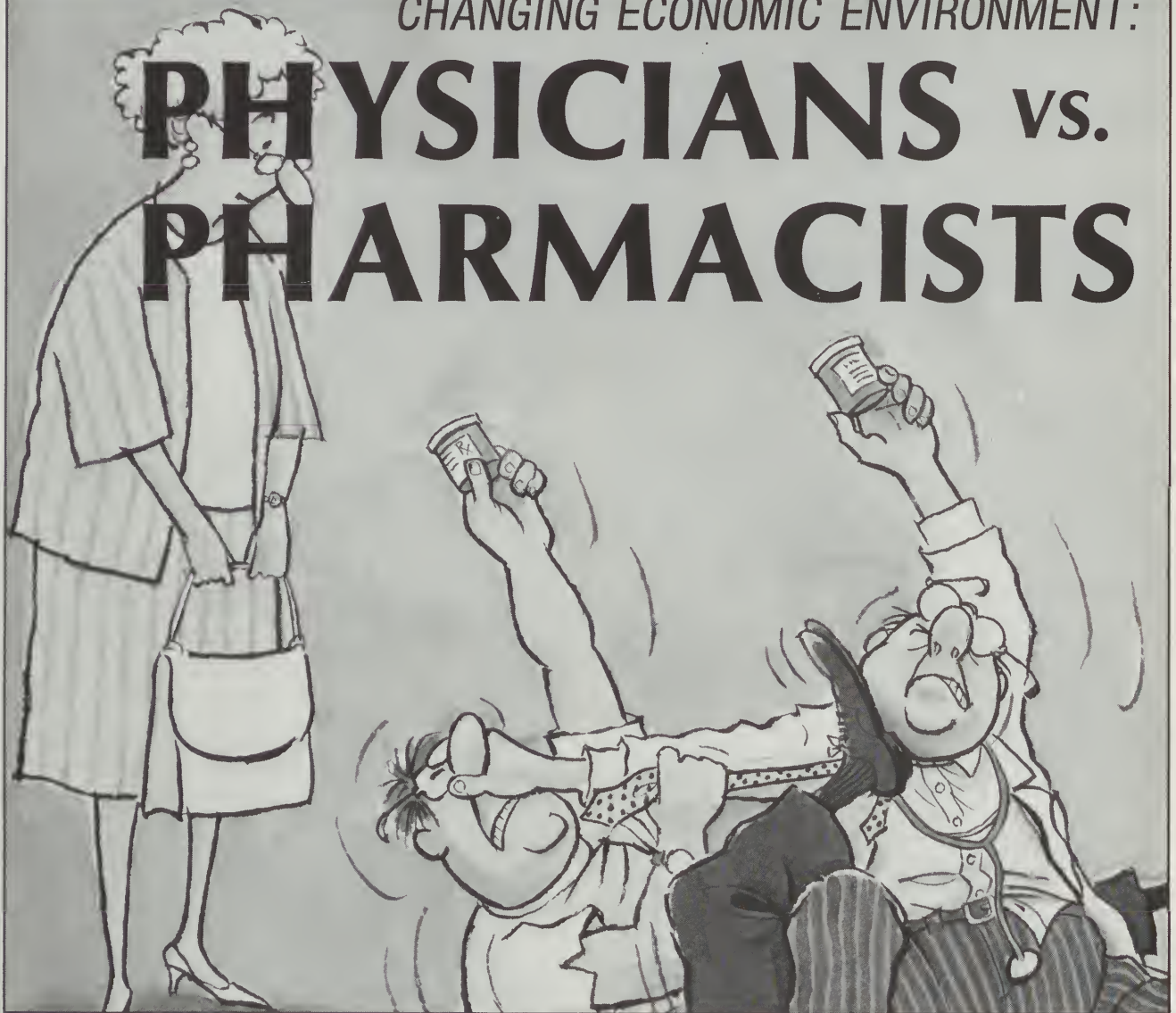
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CHANGING ECONOMIC ENVIRONMENT:

PHYSICIANS vs. PHARMACISTS



All of the health care professions have undergone rapid changes in the past several decades. The impact of consumer demand, third-party intervention, and increased competition among all the professionals has created conflicts between groups of health care providers.

The professional influence and control exerted by the physician has been challenged. Patients, their employers, and insurers have become knowledgeable consumers and demand superior care delivered in a cost-efficient manner for all Americans. Physicians have had to examine and modify their practice styles in an effort to compete in the medical marketplace.

Over the years, physicians slowly have changed their practices by introducing laboratory testing, diagnostic tests, electrocardiography, x-ray, and physical therapy. All of these modifications effectively have increased practice productivity, expanded patient options, and to a certain extent, have led to increased interprofes-

sional conflicts. With these changes, the missions of other health care providers, hospitals, and independent laboratories have been threatened. Recently, increasing numbers of physicians effectively have been dispensing drugs from their offices. This increase in consumer service has placed the physician in conflict with yet another professional—the pharmacist.

The current organization of the health care system is directly related to the history of the medical professions. The patterns of health care delivery, including the relationship between the physician and the pharmacist, have evolved through various stages. By the early 20th century, the codes of ethics regulating pharmacy and medicine already had drawn sharp distinctions between them. Diagnosis of disease and prescribing of medications were the prerogative of the phy-

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JUDITH M. CONSIDINE, PH.D., AND STEPHEN J. GOULD, PH.D., NEW BRUNSWICK*

The increased competition among health care providers has been highlighted by the furor over drug dispensing by physicians. This study examines the changing economics of medical practice, the potential impact on the cost, and subsequent control of health care delivery.

sician, while the pharmacist slowly became the sole provider of the products and an overseer able to check for prescription errors. Physician dispensing disappeared in populated areas and was a tradition in isolated rural areas, even though physicians never have been prohibited from dispensing pharmaceuticals.

The conflict between physicians and pharmacists, regarding if, and under what circumstances, should physicians dispense drugs, has come under the scrutiny of legislative bodies on both the state and federal level. The House of Representatives Energy and Commerce Subcommittee on Health and Environment considered HR-2168, a bill restricting the practice of physicians selling prescription drugs at a profit.¹²

PHARMACIST PERSPECTIVE

The pharmacist views dispensing of drugs by the physician as an intrusion both economically and professionally. When a physician offers convenient dispensing of drugs in an office setting, the local pharmacy could lose sales. Many independent pharmacists are retail merchants who depend on customers coming into the pharmacy and looking through other non-prescription merchandise during the time that the prescription is being filled. Thus, the loss of revenue may come not only from a loss of prescription drug sales, but from a loss of the sale of other merchandise as well. In addition, most physicians will dispense only those drugs they most commonly prescribe and will continue to write prescriptions for those drugs used by fewer of their patients. Small pharmacies need to be concerned about the loss of sales with a high-profit margin and with the possibility of increased inventory obsolescence.

In arguing against physician dispensing, pharmacists cite numerous concerns including an ethical conflict of interest. In a free enterprise environment, the question arises whether the pharmacist will have an equal opportunity to compete fairly for the customer's business. They believe that the open competition between individual pharmacies will be converted to a closed market: doctor and patient.

Some health care economists feel that the patient will be intimidated by the physician and be unable to make a rational choice among competing alternatives. The traditional oversight function of pharmacy provided by the separation of the prescribing and dispensing functions will be lost.³ Another often-quoted argument is that the physician will prescribe and dispense drugs from a restricted inventory and select only those drugs which his office currently has in stock, failing to consider the patient's welfare above his own revenues.

PHYSICIAN PERSPECTIVE

Consumer choice and convenience are two underlying reasons for a physician choosing to dispense drugs. In the competitive marketplace, a patient may choose a physician who dispenses drugs and offers this option to the patients. Physician dispensing saves patients time and, possibly, money. The Federal Trade Commission has issued a statement in favor of physicians dispensing drugs because it offers an alternate choice for consumers.⁴ Numerous states are considering proposals regarding this drug dispensing issue and guidelines are being prepared by various state boards.⁵ As physician dispensing has become more widespread, drug repackaging firms have emerged. These firms have made drugs available, prepackaged in the dosage increments an individual physician prescribes. As these preparations already are labeled and sealed, the potential for an error involved in office repackaging is eliminated. Many of these entrepreneurial firms also have sophisticated computerized labeling, recordkeeping, and inventory systems, which greatly simplify office dispensing.

Patient compliance is said to be improved when the physician dispenses directly to the patient.⁶ The physician can provide immediate dialogue regarding the drugs' necessity, side effects which may be encountered, and the effects of noncompliance. Studies have shown that patients prefer advice concerning pharmaceuticals from the physician rather than from the pharmacist in an acute illness.⁷ An acutely ill patient can begin the medication immediately. For chronic, long-term conditions, in-office dispensing allows the physician an opportunity to monitor a patient's long-term compliance. Reports have stated that 20 percent of all hospital admissions for chronic conditions are related to patient noncompliance with outpatient drug therapy. The cost in both lost earnings and increased medical expenses is enormous for all concerned.⁸

If generic drugs are desired, physician dispensing can introduce consistency into these maintenance regimens. Both patients and pharmacies shop for the lowest cost generic drugs, thus introducing the possibility of a patient acquiring different generic products over a period of time. The variability of different generic substitutions of the same drug can cause deviations in the baseline for the therapeutic efficacy of a given pharmaceutical product. This is caused by differences in the bioavailability among various generic medicines. The consistent use of a single generic form of a drug, as dispensed in a physician's office, would eliminate this problem.



Other positive factors include confidentiality and lower cost for the patient. Drug repackaging firms suggest a dispensing fee of approximately \$3 to \$5 over the cost of the packaged prescription.⁹ The opportunity exists for the patient to obtain a prescription immediately, thus increasing compliance, and at a cost comparable to the local pharmacy. At the same time, an extra savings might accrue to the consumer. As physicians dispense drugs, they will gain knowledge about the costs of comparable drugs. The physician may prescribe an older, less costly drug rather than prescribing the more recent additions to the formulary in situations where either will suffice.

OVERVIEW

As the number of independent pharmacies decrease and the number of discount chains increase, the once strong physician-pharmacist link has weakened. The pharmaceutical industry has responded to the increased competition with physicians with an aggressive stance on policies of generic substitution, therapeutic substitution, and pharmacist prescribing. Generic substitution allows for the substitution of name drugs with inexpensive generic drugs at presumably lower prices. Most state laws prohibiting substitution now have been repealed. Therapeutic substitution, the actual substitution by the pharmacist of one prescribed drug in a given drug class by another in the same drug class, and pharmacist prescribing have met with a more vigorous response from organized medicine. However, one state, Florida, already has legislated that pharmacists may prescribe certain selected prescription drugs.⁹ Some pharmacists have been scheduling consultations with patients to review their medications and discuss drug interactions.

Physicians and their practice managers must determine whether dispensing drugs in their practice will enhance consumer welfare. Large practices may have an advantage in that they have the personnel to handle the inventory and added paper work. However, if greater numbers of physicians institute drug dispensing for patient convenience and compliance, all individual practitioners may have to consider this possibility to remain competitive.

FUTURE DEVELOPMENTS

The anticipated increase in physician dispensing of

medications in the office may force pharmacists to strive for a role greater than that of a prescription dispenser and retailer. An opportunity is presented to put their knowledge of drugs and drug interactions to good use as a patient consultant and advisor. They need to render a service as a health care professional who is concerned with patients' welfare.

Physician dispensing likely will increase patient compliance, offer increased service, and promote lower prices in the retail drug area. In addition, the physician can establish better doctor-patient communication, which is necessary for accurate diagnosis and treatment.

Economically, more pharmacists may be forced to accept the various drug insurance programs offered as part of the benefit package by large corporations. For corporate benefit managers, this trend must be observed closely in order to determine its overall effect on health care costs.

The continuing evolution of the interrelationships of professions and changing consumer attitudes have a great influence on health care delivery. Simultaneously, political and social pressures have mandated change. Along with the many recent changes in health care delivery, physician dispensing currently is one of the most controversial. The benefits derived by the consumer will determine the outcome of this conflict. The most important consideration is quality care.

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Axid is indicated for maintenance therapy for duodenal ulcer patients, at a reduced dosage of 150 mg b.i.d., after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H₂-receptor antagonists.

Precautions: General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

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Drug Interactions:—No interactions have been observed between Axid and theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility:—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose related increase in the density of enterochromatin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice; although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement

compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C:—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

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Pediatric Use:—Safety and effectiveness in children have not been established. **Use in Elderly Patients:**—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to

determine whether these were caused by nizatidine.

Hepatic:—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular:—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine:—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic:—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H₂-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumentary:—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other:—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD₅₀ values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

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MEASLES EPIDEMIC IN NEW JERSEY: 1985-1986

JOHN PORTER, M.D., M.P.H., TRENTON*

Between November 15, 1985, and June 30, 1986, 905 cases of measles were reported in northern New Jersey, principally among preschool children. This outbreak could have been prevented by the early recognition and reporting of measles cases and in ensuring age-appropriate vaccination of all children.

Measles outbreaks from 1980-1985 have occurred predominantly in school and college-age children.^{1,2} In 1985-1986, an outbreak in New Jersey occurred which differed from these recent patterns in that it affected primarily preschoolers. This report describes the epidemiologic characteristics of this measles outbreak, the assessment of immunization levels in affected communities, and aspects of epidemic control.

BACKGROUND

After five years of reports of less than ten cases of measles annually, New Jersey experienced a large outbreak in 1985-1986 with 905 cases. The majority of the cases were reported from Jersey City, a socioeconomically depressed community of 560,000 in the northeastern part of the state. A second focus of disease occurred in Paterson in bordering Passaic County, with a population of 450,000. Both counties have substantial Hispanic communities: 104,000 Hispanics in Hudson County and 42,000 Hispanics in Passaic County.

New Jersey law requires all children attending public or private school (including child-care centers, nursery schools, and kindergartens) to be appropriately vaccinated against measles on or after the first birthday.⁶ Religious exemptions are permitted under state law.

METHODS

Definition. A measles case was defined as a person with generalized maculopapular rash of more than three days' duration; fever (101° F, if measured); and at least one of the following: cough, coryza, or conjunctivitis.⁴ A person was considered to have adequate evidence of immunity if immunized with measles vaccine at more than 12 months of age, or if there was a history of physician-diagnosed measles. A case was considered preventable if a person was more than 16 months of age, was born after 1956, lacked evidence of immunity to measles (as defined), had no medical contraindication to receiving measles vaccine, and had no religious exemptions under state law.

Surveillance. The New Jersey State Department of Health collects information on all suspected measles cases. By law, any suspected case must be immediately reported to the Department; the case is investigated by a staff member, and a surveillance form is completed.⁵ The data collected include: name, age, address, sex, symptoms, vaccination status, and transmission set-

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TABLE 1
Age Specific Attack Rates for Measles
Measles Outbreak, 1985-1986.

<i>Age</i>	<i>Cases</i>	<i>Estimated Population of Area Affected</i>	<i>Age Specific Attack Rate</i>	<i>Percentage of Cases</i>
Unknown	15	—	—	1.7
<12 months	163	14,700	11.0/1000	18.0
12-15 months	96	13,300	7.2/1000	10.6
16 months-4 years	272	39,100	7.0/1000	30.1
5-9 years	121	68,900	1.8/1000	13.4
10-14 years	127	77,900	1.6/1000	14.0
15-19 years	49	88,700	0.6/1000	5.4
20-27 years	41	170,300	0.2/1000	4.5
28+	21	531,500	0.1/1000	2.3
Total	905	1,004,400	0.9/1000	100.0

TABLE 2
Age Distribution and Preventability Status of Measles Cases
Measles Outbreak, 1986

<i>Age at Onset</i>	<i>Preventable No./%</i>	<i>Nonpreventable No./%</i>	<i>Unknown No./%</i>	<i>Total</i>
Unknown	—	—	15 (100)	15
<12 months	NA	163 (100)	0 (0)	163
12-15 months	NA	96 (100)	0 (0)	96
16 months-4 years	237 (87)	26 (10)	9 (3)	272
5-9 years	13 (11)	99 (82)	9 (7)	121
10-14 years	7 (6)	114 (90)	6 (5)	127
15-19 years	9 (18)	37 (76)	3 (6)	49
20-27 years	12 (29)	20 (49)	9 (22)	41
28+	1 (5)	20 (95)	0 (0)	21
Total	279 (31)	575 (64)	51 (5)	905

NA = not applicable

TABLE 3
Measles Vaccination Coverage Surveys of School Entrants
by Age of Receiving Measles Vaccine
Measles Outbreak, 1986

<i>Area</i>	<i>Percentage of Children Vaccinated with Measles</i>			<i>Percentage of Children Vaccinated with Measles</i>		
	<i>1981 Survey Months of Age</i>			<i>1986 Survey Months of Age</i>		
	24	48	60	24	48	60
Urban (mean of all schools)	55	80	97	63	85	99
Jersey City	56	76	98	60	82	98
Paterson	50	80	98	60	83	99
Suburban (mean of all schools)	81	92	98	79	93	99

Urban = selected urban schools in Passaic and Hudson Counties, including schools in Jersey City and Paterson.

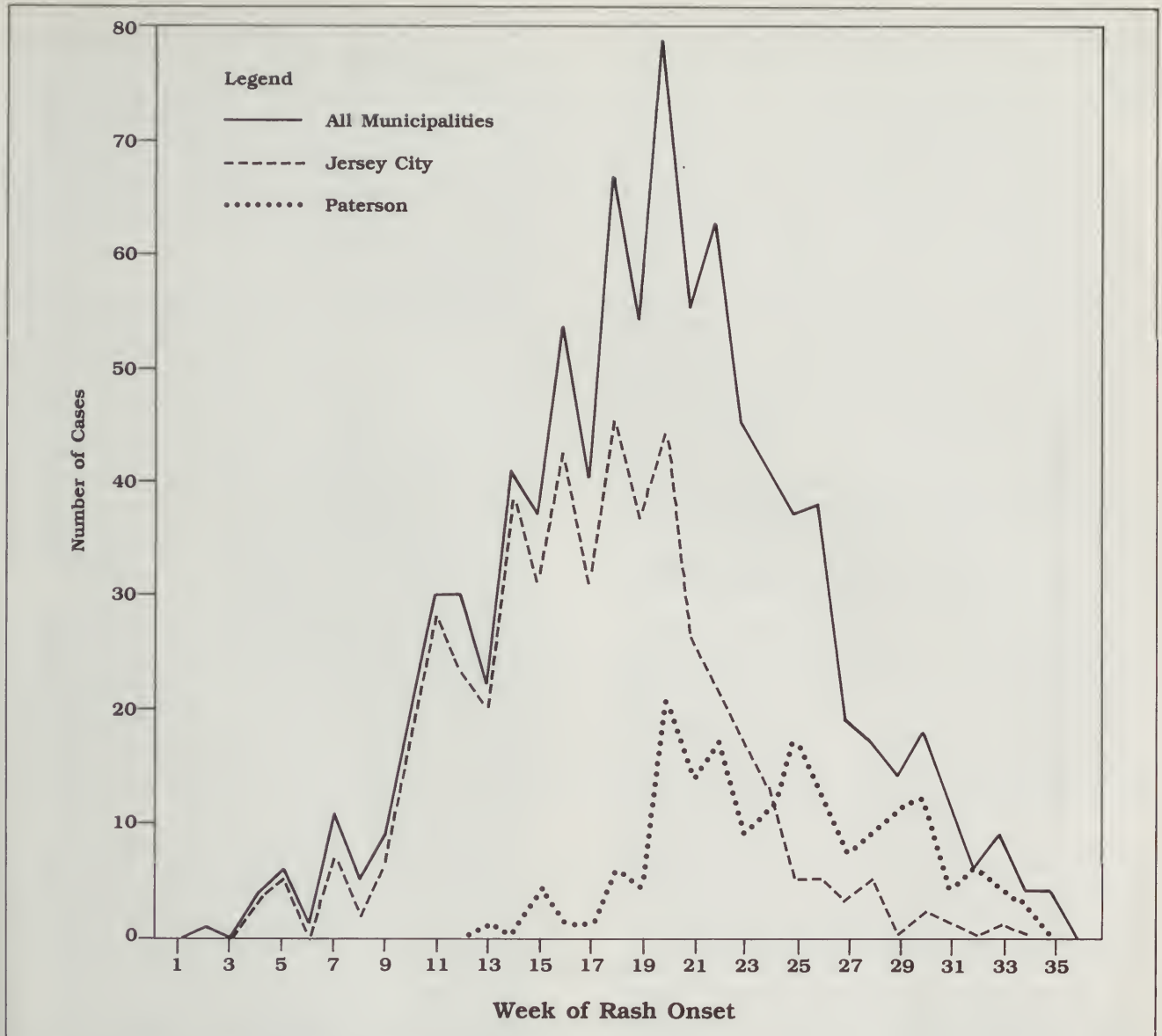


Figure 1—Measles cases by week of onset in 1986.

ting, as well as information on possible contacts. No information on race is routinely requested; however, during this outbreak, surnames were used as a means of differentiating Hispanic from non-Hispanic cases.

Rates of disease were calculated using population data from the 1980 New Jersey census. In addition, some adjusted census information was available for the years 1981 to 1983. Because the age categorization of the population census was different from that needed for the calculation of relevant age-specific measles incidence rates, age population estimates were made from the available data.

Paired serum samples were obtained from 165 of the case-patients and were stored at -20°C . Cases with a fourfold or greater rise in titer of hemagglutination-inhibiting (HI) and/or complement-fixing (CF) antibody to measles, were considered to be seroconfirmed.

Immunization levels in the areas affected by the outbreak were assessed using two surveys. In the first study, all immunization records in child-care centers and schools in the areas where measles cases were occurring, were audited for age-appropriate vacci-

nations and studied. The second study was of new school entrants for the 1985 to 1986 school year. (This survey was conducted in a sample of schools that had been selected randomly from all schools in urban and suburban municipalities. These same schools had been chosen for the last survey after the previous epidemic in 1980.)

The purpose of the study was to determine at what ages children were vaccinated against measles in order to determine if there had been an improvement in age-appropriate vaccination between 1981 and 1986. Urban schools were those within city limits. Suburban schools were situated outside city limits and were in municipalities surrounding areas affected by the measles outbreak.

RESULTS

Descriptive Epidemiology. Between November 15, 1985, and June 30, 1986, 905 clinically confirmed cases of measles were identified (Figure 1). A total of 9.7 percent (88/905) of the measles cases were serologically confirmed. The index case was a 30-month-

old Hispanic child, a resident of Jersey City, who developed a maculopapular rash on November 15, 1985. He had received measles/mumps/rubella (MMR) vaccination at the age of 15 months. The source of his infection was unknown.

The site of the outbreak was the northeastern part of New Jersey. The early cases and, ultimately, the majority of cases (489/905, 54 percent) were reported from Jersey City. However, on March 25, 1986, there was evidence of a sustained outbreak occurring in the neighbouring city of Paterson (Figure 1).

Overall, 59 percent of reported cases (531/905) were in preschool children less than five years of age. Among these, 163 (18 percent) cases were more than 12 months, 96 (11 percent) cases were 12 to 15 months, and 272 (30 percent) cases were in the 16-month to four-year age group. Early in the outbreak, very young children were involved; 16 of the first 23 cases reported (70 percent) involved children less than 15 months of age. The age-specific attack rate was high for children less than 12 months of age (11.0/1,000), with a rate of 7.0/1,000 in children from 16 months to four years of age. Age-specific attack rates decreased with increasing age (Table 1).

Of the 905 cases, 31 percent (279/905) of the cases were defined as preventable (Table 2). Among the 263 preschoolers more than 15 months of age, 237 (90 percent) cases were preventable, 234 cases were unvaccinated, and 3 cases had been vaccinated at less than 12 months of age. Of the 575 nonpreventable cases, 45 percent (259/575) were less than 15 months of age, 51 percent (296/575) had a history of vaccination, and 4 percent (20/575) either were born before 1956 or had a medical or religious exemption. Ten percent (26/263) of cases among preschoolers (16 months to four years) were not preventable compared with 90 percent (250/279) of cases among school-age children.

Thirty-one percent (276/905) of the total outbreak occurred in people with Hispanic surnames. The race-specific data for Jersey City showed an attack rate of 4.0/1,000 for the Hispanic community (total Hispanic population = 36,000) compared with an attack rate of 0.8/1,000 for non-Hispanics.

There were no measles deaths during this epidemic. However, a total of 16.5 percent (149/905) of cases had a measles complication; including 60 cases of pneumonia, 35 cases of otitis media, and 1 case of encephalitis. Twenty-four percent (36/149) of complications occurred in children less than 12 months of age, 14.8 percent (22/149) in 12 to 15 month olds, and 35 percent (52/149) in the 16-month to four-year age group. Fourteen percent (126/905) of all persons with measles were hospitalized.

Assessment of Immunization Levels. In Jersey City, all the schools were audited for their measles immunization status and a measles coverage of more than 98 percent was found. Fifty-four child-care centers in the city, with a total enrollment of 1,558 children, were similarly investigated and a total of 160 of these children (10 percent) had not received measles vaccination.

In Paterson, 24 child-care centers with a total of 1,620 children were audited. Ten percent of these children were not immunized against measles and in one center, only 31 percent (14/45) of the pupils had re-

ceived appropriate measles vaccination.

The results of the school entrants' survey showed that suburban municipalities had better immunization rates for measles than urban municipalities (Table 3). Compared to the retrospective survey in 1981, vaccination levels had improved slightly in urban areas. In Jersey City, measles vaccination levels increased from 56 percent at 24 months of age in the 1981 survey, to 60.2 percent in the 1986 survey with measles vaccination levels in suburban areas remaining essentially unchanged.

Control Measures. Control measures were directed at the vaccination of preschoolers, the prevention of transmission in schools, and the prevention of transmission in medical-care settings. To address the first control measure, additional vaccination clinics were established in schools, clinics for women, infants, and children (WIC), and emergency rooms of local hospitals. Also, a mobile vaccination unit travelled around the city administering the vaccine to children in the housing projects. Information about the vaccination clinics and the progress of the epidemic were prepared for both the Spanish and English news media.

Because of the large percentage of measles cases occurring in children less than 15 months of age (33 percent of the total cases as of February 23), the age for vaccination was lowered to 12 months, initially in Jersey City alone, but later in affected surrounding counties. In April, the vaccination age in Jersey City was lowered further to 6 months because more than 15 percent of cases were occurring in children less than 12 months of age.

Vaccine administration was most successful in the WIC clinics and in certain emergency rooms. There was, however, a poor response to the special clinics (mean of 11 vaccinations/clinic) and to the mobile vaccination unit (177 vaccinations in three weeks) in these areas.

To prevent measles transmission in schools and child-care centers, unvaccinated children were excluded from the institution until they had received a measles vaccination. In order to prevent measles transmission in medical-care settings, specific recommendations were made: there be triage and isolation of measles cases in outpatient clinics, emergency rooms, and pediatric departments; persons with suspected measles cases were to be scheduled for appointment when few or no other patients were expected to be present; hospitalized patients with measles were to be nursed in strict respiratory isolation throughout their infectious period; and all staff should be appropriately vaccinated against the disease.

DISCUSSION

This measles outbreak is different from most of the recent U.S. outbreaks,¹⁻³ but is similar to the pattern seen in the pre-vaccine era. The majority of cases occurred among preschool age children in an urban municipality which was found to have low levels of measles immunization among its preschoolers. There is only one recent report of a similar outbreak and that occurred in Chicago in 1983.⁷ Following the New Jersey outbreak of 1986, there have been similar reports of preschool epidemics in New York City and in Miami.⁸

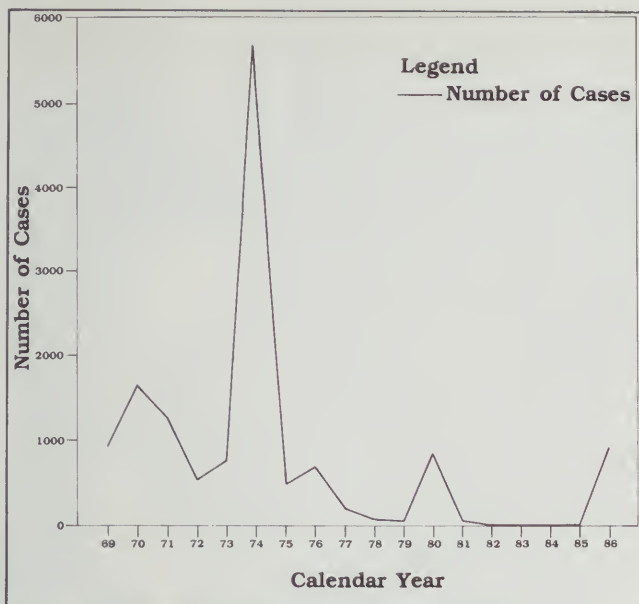


Figure 2—Measles cases from 1969 to 1986.

The New Jersey outbreak was started in preschoolers and remained predominantly among this age group. One reason for preschool transmission was that in Jersey City and Paterson, only 60 percent of children entering school in 1985 had received their measles vaccination before their second birthday. We can assume, therefore, there was a large pool of children susceptible to measles, who subsequently became infected following the introduction of the virus into the community in November 1985.

As the control measure data demonstrates, it was difficult to improve the vaccination levels among preschoolers. But, why are preschool children not being vaccinated? Many reasons have been suggested: the perception of measles as a mild disease, the lack of education of parents in disease prevention, and the general apathy of the population to childhood infectious diseases. Unfortunately, we were unable to obtain information on these subjects, but studies are needed to determine the specific reasons why children fail to receive appropriate measles vaccination. With this additional information, resources can be directed at the education of appropriate parent groups. Our data in-

dicated that the outbreak was sustained in an urban area with the highest attack rate for disease occurring among the Hispanic community. Future measles outbreaks need to determine if being Hispanic and living in an urban area makes it less likely for a child to be appropriately vaccinated against the disease.

Measles epidemics in New Jersey have occurred at approximately five-year intervals since 1969 (Figure 2). Despite the increased vaccination levels among school-age children during the past five years,⁹ large numbers of susceptible preschoolers were able to sustain transmission in this outbreak. Unless preschool-age vaccination can be increased to a level of more than 90 percent,¹⁰ there always will be a risk of further periodic epidemics occurring in the state. Pediatricians and other health-care workers must ensure that all children in their practices have been appropriately vaccinated.

There are reports from both New York and Florida that recent measles outbreaks in these states also have been occurring in preschool-age children.⁸ This information indicates that in order to prevent further measles outbreaks, all states need to investigate the immunization coverage of their preschoolers and to establish innovative campaigns to encourage and ensure age-appropriate vaccination of their preschool children.

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Governor Thomas H. Kean (right) signs bill into law as New Jersey State Medical Underwriters, Inc. President Peter Sweetland (left) and Chairman Henry J. Mineur, M.D. (center) look on.

CASE REPORT: CONJOINT THERAPY WITH A DEAF AND MUTE COUPLE BY A HEARING THERAPIST

RAKESH K. BANSIL, M.D., AND CARMELO A. COLÓN, M.S.S.W., NEWARK*

We describe a case of successful conjoint therapy with a deaf and mute couple, including discussions of the psychiatric aspects of deafness in general and the specific influence of an interpreter in therapy with the deaf.

By definition, psychotherapy is an art and science that employs verbal and nonverbal modes of communication as the primary tools for treatment. Inability to communicate freely due to hearing impairment, thus, poses a major challenge. Few adequate descriptions of psychotherapy for the deaf are to be found in the literature and there is a paucity of mental health personnel to treat this population. However, successful cases of family therapy,¹ group therapy,² behavior therapy,³ psychodrama,⁴ and psychoanalysis⁵ of the deaf and mute have been described in the literature. To the best of our knowledge, this is the first case report of conjoint therapy with a deaf and mute couple.

CASE REPORT

Mr. C. is a 31-year-old male and has been deaf since the age of 2. He was abandoned by his mother at an early age and was raised by his grandmother. He remained in an institution for the mentally retarded from age 5 to 12 and received little formal education because he was considered mentally retarded. Subsequently, he broke all bonds with his family and on his own learned to lip read and communicate in sign language.

Mrs. C. is a 32-year-old female who has been deaf since birth. She was raised by an alcoholic and physi-

cally abusive mother and a passive and emotionally uninvolved father. She attended a special school for the deaf and learned lip reading and sign language. She also suffers from severe scoliosis of the spine and has had several corrective surgical operations. Periodically, she goes through bouts of depression and claims that, at such times, alcohol has been the source of relief for her.

Mr. and Mrs. C. have been married for the past eight years and were referred for outpatient psychiatric treatment in September 1984 by the New Jersey Division of Youth and Family Services (DYFS), because of alleged incidents of sexual abuse of their five-year-old daughter by Mr. C. At the time of our initial contact, Mr. C. was separated from his wife at the suggestion of DYFS and their daughter was placed in temporary physical custody of her maternal grandmother.

The couple has been seen for 51 sessions of conjoint therapy. The majority of our sessions were assisted through the services of a sign interpreter. When the interpreter was absent, communication was limited to the written mode.

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As therapy progressed, Mr. C. began to acknowledge his outbursts of anger and was able to sit with his wife and participate in mature dialogue. Mrs. C. began to acknowledge that Mr. C. was a source of support for her and she significantly reduced her drinking.

Normal physical examination of the child in question and lack of evidence of sexual abuse on further investigations led the court to drop all charges against Mr. C.

By September 1985, their problems were sufficiently resolved to the point they decided to end their formal separation. In subsequent sessions, Mr. and Mrs. C. continued to show gradual progress. With our support, in April 1986, the broken family was reunited and continues to live relatively happily.

DISCUSSION

This case allows us to review certain issues regarding the psychiatric aspects of deafness, in general, and the influence of an interpreter in therapy with the deaf, specifically. The findings in the literature are evident in this case: deaf patients often come to treatment not through self-referral, but rather because someone referred them;⁶ they tend to be regarded as mentally retarded;⁷ and they tend to be rejected by their family.¹

The majority of our sessions were conducted through an interpreter. The influence of an interpreter in therapy with the deaf has been discussed.⁸⁻¹¹ Clearly, an interpreter makes listening and understanding less tiring for both the patient and the therapist. Nonetheless, there are problems inherent in using an interpreter that can noticeably alter or hinder therapy. Most of these problems revolve around the triangular nature of interaction with the interpreter at the apex. This arrangement often results in a loss of visual and emotional contact between the therapist and the patient, it dilutes the transference, and may lead to the loss of therapist credibility. Many of the signs of mental illness, e.g. the thought disorder in schizophrenia, the retardation of thought in depression, the pressure of speech in mania, are all appreciated through normal spoken language and any degree of communication difficulty will interfere with their appreciation. A good interpreter, of course, should try to convey affective nuance and emphasis by voice when speaking what the patient has communicated in signs. It also is necessary that the interpreters maintain strict neutrality; disapproval of the way therapy is being con-

ducted can clearly undermine the therapist's efforts to effect any change. The therapist needs to be aware that negative countertransference feelings are likely to develop because of the exhaustive nature of the sessions, feelings of powerlessness, and lack of connectedness with the patient. Perhaps a major factor contributing to the successful therapy in this case was the support Mr. and Mrs. C. provided for each other. Nonetheless, we feel that despite these difficulties, deaf patients can be successfully treated by hearing therapists through the utilization of an interpreter and, furthermore, it can be an extremely rewarding experience.

CONCLUSION

Ideally, deaf and mute persons who have emotional difficulties should be treated by mental health professionals who can communicate through sign language. However, because of the paucity of therapists who are trained in sign language, it is more likely that an interpreter will be used to conduct therapy with this population. An understanding of the psychiatric aspects of deafness and, specifically, the influence of an interpreter in therapy are essential for the treatment to be effective.

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CASE REPORT: ANTERIOR DIAPHRAGMATIC HERNIA (HERNIA OF MORGAGNI)

CHARLES VALASES, M.D., AND CHARLES SILLS, M.D., LONG BRANCH*

The anterior diaphragmatic hernia (hernia of Morgagni) occurs as a result of congenital weakness of the parasternal portions of the diaphragm. Most are asymptomatic, and often are detected incidentally on chest x-ray. Once it is diagnosed, surgical repair is mandatory.

The embryogenesis of the diaphragm is a complex process occurring between weeks 8 and 10 of development. A number of congenital diaphragmatic defects may occur, and have been classified: 1) partial or complete absence of the diaphragm; 2) posterolateral defects of the pleuroperitoneal membrane (foremen of Bochdalek); 3) parasternal defects (foramen of Morgagni); 4) eventration of the diaphragm; 5) defects of the septum transversum; and 6) defects of the esophageal hiatus.¹

Of the congenital herniations through the diaphragm, the posterolateral hernia (of Bochdalek) is the most frequent. It manifests as acute respiratory distress in the newborn.² The hernia of the foramen of Morgagni is much less common, and usually is asymptomatic during childhood.

We present a case of a Morgagni hernia in a teenage male which became symptomatic shortly after he began to engage in the strenuous sport of weightlifting. A discussion of the pathogenesis, symptomatology, diagnosis, and surgical management of Morgagni hernias also is included.

CASE REPORT

A 14-year-old white male on a routine sports physical examination was found to have an asymptomatic resting tachycardia of 120 beats per minute. He com-

plained of "pounding" in his head while running, as well as vague discomfort of the lower thoracic spine region. At the age of 10 years, he had been diagnosed as having asthma, and was placed on an oral theophylline preparation. For the past 2 years, he regularly engaged in the sport of weightlifting.

A chest x-ray (Figure 1) demonstrated a large homogeneous soft tissue mass of the right pericardio-phrenic region, located in the anterior mediastinum (on the lateral film). A roentgenogram of the chest performed three years prior to this x-ray was reported as normal. The computed tomography (CT) scan of the chest (Figure 2) demonstrated a large mass of the anterior mediastinum abutting the right cardiac border. It had the density of fat. Preoperatively, it was felt that this represented a mediastinal lipoma possibly related to the pericardium.

Through a median sternotomy incision, the mass was found to be omentum (10 to 12 cm in diameter), which had herniated into the mediastinum (Figure 3). It arose through a 5 cm diaphragmatic defect of the right foramen of Morgagni (Figure 4). The hernia sac and contents were reduced through the diaphragmatic

*Dr. Valases is a surgical resident and Dr. Sills is chief of thoracic surgery, Monmouth Medical Center. Correspondence may be addressed to Dr. Valases, Department of Surgery, Monmouth Medical Center, Long Branch, NJ 07740.



Figure 1—Chest x-ray demonstrating a homogeneous soft tissue mass of the right pericardiophrenic region.

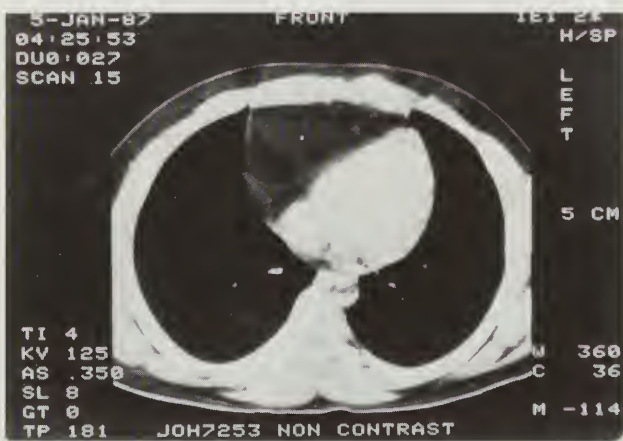


Figure 2—CT scan of the chest demonstrating an anterior mediastinal mass abutting the right cardiac border.

defect which then was primarily reapproximated with interrupted Surgilon[®] sutures. The margins of the defect were attenuated, almost membranous; therefore, the suture line was reinforced with a Gortex[®] patch sutured over the repair with prolene sutures.

The patient's postoperative course was unremarkable except for a superficial wound infection. At the time of hospital discharge, his tachycardia had resolved, his chest x-ray demonstrated a normal cardiac shadow, and he no longer required bronchodilators.

DISCUSSION

The anterior diaphragmatic hernia (hernia of Morgagni) originally was described in the latter part of the 18th century by Giovanni Morgagni. The herniation occurs through the foramen of Morgagni (or spaces of Larey, or parasternal spaces). These foramina are bounded medially by diaphragmatic muscle from

the xiphoid process, and laterally by diaphragmatic muscle from the costal cartilages.¹ It is through these spaces that the superior epigastric vessels penetrate the diaphragm.

Embryologically, the central tendinous portion of the diaphragm develops from the septum transversum, and attaches to the costal cartilages and to the sternum.² The muscular portion of the diaphragm has its origin from the xiphoid process, the lower ribs, and the posterior costal cartilages. It inserts on to the central tendon of the diaphragm.³ If there should be a partial or incomplete fusion of the muscle fibers originating from the xiphoid process and from the ribs, an area of congenital weakness then exists in the parasternal portion of the diaphragm. Due to the lack of adequate muscularization, this area then becomes membranous.⁴ These weakened areas are triangular spaces on either side of the xiphoid process.

Morgagni hernias are relatively rare, accounting for 3 percent of diaphragmatic hernias.⁵ At the Texas Children's Hospital, over a 25-year period, only five infants were treated for a Morgagni hernia.⁶

For the most part, Morgagni hernias are asymptomatic. It either is detected incidentally on chest x-rays, or it becomes symptomatic in adulthood. The symptoms usually are restricted to vague epigastric discomfort. Situations which result in increased intra-abdominal pressure,⁷ such as obesity, trauma,⁸ and, in our case, weightlifting, are precipitating factors.

The herniation may occur on either side of the xiphoid, but 90 percent occur on the right side.⁸ Omentum and preperitoneal fat are the most common contents of the hernia,⁵ although bowel or stomach also may herniate. There have been reports of gastric volvulus occurring within a Morgagni hernia.⁹

The herniation most commonly is detected on chest x-ray as a smooth, supradiaphragmatic shadow at the right pericardiophrenic angle. If it contains only fatty tissue, i.e. omentum, it presents as a homogeneous mass which must be differentiated from other mediastinal masses, e.g. neoplasms, lipomas, and from cardiomegaly.⁵

If the contents of the hernia also include bowel, gas usually can be detected within the hernia on the roentgenograms. This finding makes the diagnosis more readily apparent, and confirmed more easily by upper or lower gastrointestinal contrast studies.

Once the diagnosis has been established, most authorities agree that surgical repair is mandatory, even in the asymptomatic patient.^{4,10} The surgical approach may be transabdominally or transthoracically, or via a combined upper laparotomy and lower median sternotomy.¹¹ If the defect is small, it may be repaired primarily. If it is large, or the diaphragmatic margins are attenuated, a Gortex[®] patch may be used to reinforce the suture line. The patch also may be used to bridge the defect as is done with large posterolateral (Bochdalek) hernias.¹²

SUMMARY

Morgagni hernias are relatively rare diaphragmatic defects. The diagnostic evaluation, in addition to the routine chest roentgenogram, also includes CT scanning, and upper and lower gastrointestinal contrast studies. The diaphragmatic defect may be repaired



Figure 3—A large right anterior diaphragmatic hernia. The hernia sac and its contents (omentum) are being held as they protrude through the diaphragmatic defect into the right hemithorax.



Figure 4—The anterior diaphragmatic defect at the right foramen of Morgagni. The hernia sac and contents have been reduced through the defect back into their normal infra-diaphragmatic location. The margins of the defect are being held by the sutures.

either transthoracically or transabdominally, resulting in a surgical cure.

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HIGHLIGHTS FROM THE 222ND ANNUAL MEETING

The Medical Society of New Jersey's 222nd Annual Meeting was held at the Sheraton Meadowlands Hotel in East Rutherford from April 28, 1988, to May 1, 1988.

Reverend Doctor Louis G. McAfoos, Jr., from the Grace Episcopal Church in Haddonfield delivered the invocation. Lindsay L. Pratt, M.D., Chairman of the Committee on Credentials presented his report to the House of Delegates. Following was the announcement of appointments: George T. Hare, M.D., Chief Teller; Michael J. Gentlesk, M.D., Chief Sergeant-at-Arms; and Janet I. Geraghty-Deutsch, M.D., Timothy M. Hosea, M.D., and Charles Zwerling, M.D., Sergeants-at-Arms.



The 1988-1989 MSNJ Board of Trustees: (seated left to right): Bernard Robins, M.D.; Paul J. Hirsch, M.D.; Palma E. Formica, M.D.; Douglas M. Costabile, M.D.; Joseph N. Micale, M.D.; Harry M. Carnes, M.D.; (standing left to right) Joseph P. Zawadsky, M.D.; George L. Triebenbacher, M.D.; Carl Restivo, Jr., M.D.; Herman M. Robinson, M.D.; R. Gregory Sachs, M.D.; Michael M. Heeg, M.D.; Louis L. Keeler, M.D.; Frank Gingerelli, M.D.; Fred M. Palace, M.D.; Edwin W. Messey, M.D.; Joel S. Cherashore, M.D.; Scott Lauer; Shah M. Chaudhry, M.D.; and John J. Pastore, M.D. Absent: Joseph A. Riggs, M.D., and Gerald H. Rozan, M.D.



Speaker of the House Henry J. Mineur, M.D., begins the 222nd Annual Meeting of the Medical Society of New Jersey.



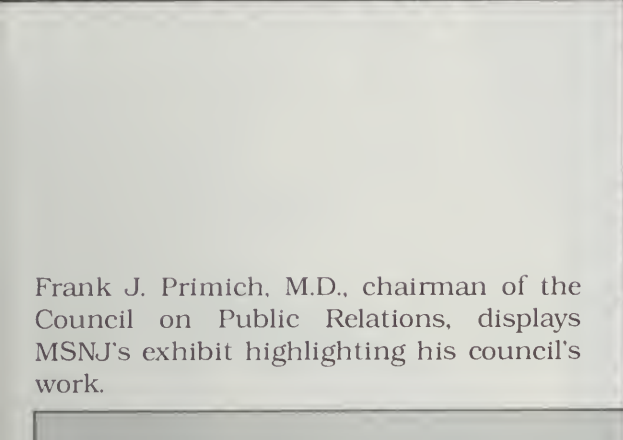
President Palma E. Formica, M.D., is congratulated by Harry M. Carnes, M.D.



William E. Ryan, M.D., chairman of the Board of Directors of JEMPAC, presents an award to Kathy Gavett of AMPAC.



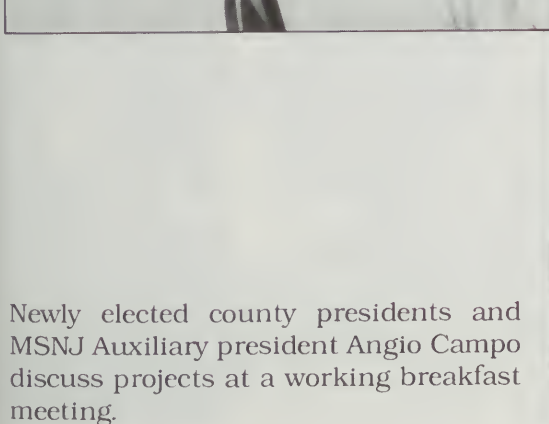
Members of our Bergen County component and executive director George Willis (top, left) accept their honors at the 32nd Annual Golden Merit Awards.



Frank J. Primich, M.D., chairman of the Council on Public Relations, displays MSNJ's exhibit highlighting his council's work.



Angio Campo, president of the Auxiliary (second from right, seated), meets with Auxiliary fellowettes.



Newly elected county presidents and MSNJ Auxiliary president Angio Campo discuss projects at a working breakfast meeting.



Palma E. Formica, M.D., and family at her inaugural reception at the Sheraton Meadowlands Hotel.




James S. Todd, M.D., MSNJ honorary fellow, greets Dr. Formica, president-elect Paul J. Hirsch, M.D., and past-president Dr. Carnes.



MSNJ executive director Vincent Maressa and his wife Arlene celebrate at the dinner-dance held in Dr. Formica's honor.



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**Trustees' Minutes;
UMDNJ Notes;
New Members;
Physicians Seeking
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Trustees' Minutes April 27, 1988

A regular meeting of the Board of Trustees was held on Wednesday, April 27, 1988, at the Sheraton Meadowlands Hotel, East Rutherford. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Check Presentation . . . Noted that Mrs. Richard Lorber, chairman of the MSNJ Auxiliary American Medical Association Education and Research Foundation Committee, presented four checks totalling \$34,460.68 to Dr. Bergen, president of UMDNJ.

Report of the President . . .
MSNJ Special Assessment . . . Heard that payment of the special \$100 assessment was mandated before any delegate was seated in the 1988 House of Delegates.

Report of Executive Director . . .
(1) MSNJ Paid Membership . . . Noted that paid memberships through March 1988 total 6,669.
(2) Financial Statements . . . Reviewed and approved the financial

statements for the period ending March 31, 1988.

(3) Preadmission Certification/Utilization Review . . . Directed that an appropriate letter be sent to the commissioner of insurance objecting to the proposed regulations, and setting forth MSNJ's position that review on all patients hospitalized in New Jersey must be conducted by certified utilization review organizations through the Department of Health.

(4) Medicaid Fees/Garden State Health Plan . . . Heard that Mr. Maressa reaffirmed the Society's position recognizing the Garden State Health Plan as a new, innovative, and potentially viable method of delivering quality health care to Medicaid recipients; and that MSNJ appreciates the decision to implement the plan on a voluntary basis for patients and physicians.

UMDNJ Report . . . Noted Dr. Bergen's report highlighting the following: the Senate passed S-1014 which provides participants in accredited graduate education programs a temporary license not to exceed a six-year period; and activity has been observed at all levels toward having a single examination for all applicants for entry into graduate medical education, and a single examination for licensure.

Council on Legislation . . . Approved all the positions recommended by the Council on Legislation with the exception of the following: (1) S-1963-Rice—HIV Antibody Testing: position changed to conditional approval; (2) A-267-Felice—Pharmacy: position changed to action deferred; (3) A-271-Felice—Osteoporosis: position changed to disapproved; and (4) A-472-Colburn—Certificate of Need: position changed to action deferred.

Report by MSNJ Lobbyist . . . Noted Clark Martin's meeting with William B. Brown (D), new minority leader of the New Jersey State Assembly, for a discussion on the bill for mandatory assignment of Medicare fees.

New Business . . .

(1) PRO Contract . . . Voted to postpone consideration of Dr. David I. Kingsley's request for support from MSNJ to accompany PRO's current bid for the New Jersey peer review contract.

Trustees' Minutes May 1, 1988

A reorganization meeting of the Board of Trustees was held on Sunday, May 1, 1988, at the Sheraton Meadowlands Hotel, East Rutherford. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Reorganization . . . Officially welcomed Shah M. Chaudhry, M.D., the newly elected trustee from the fifth district; Scott Lauer, the newly designated student member; Paul J. Hirsch, M.D., president-elect; Douglas M. Costabile, M.D., first vice-president; Joseph A. Riggs, M.D., second vice-president; and Mrs. Frank Campo, newly elected president of the MSNJ Auxiliary. Also, voted to continue holding regular Board meetings on the third Sunday of each month at 10 A.M. at MSNJ headquarters.

Referrals from 1988 House of Delegates . . . Noted that complete information appears in the Transactions section of this issue.

(1) Substitute Resolution #20—Addressing the Shortage of Nursing and Technical Personnel . . . Authorized the president to appoint a task force to address the shortage of nurses and technical personnel problem.

(2) Resolution #22E—Senior Medical Courtesy Programs . . . Directed that the president or her designee send appropriate letters to the county medical societies, and to the individual members of MSNJ to implement the Resolution calling for senior medical courtesy programs.

(3) Resolution #2—Repeal PRO Law . . . Approved referral of this Resolution to the AMA Delegation for preparation of an appropriate resolution to be introduced to the AMA House of Delegates.

(4) Resolution #5—Accountability of Claim Review Workers . . . Directed that the president or her designee send an appropriate letter to the State Board of Medical Examiners to implement this Resolution encouraging the SBME to consider that those making decisions with regard to payment should be held accountable in the same way as the treating physician is held accountable.

(5) **Resolution #6—Billing for Preparation of Medical Information for Third Parties . . .** Directed that an article on this Resolution be prepared by the president for publication in the *Membership Newsletter* and for inclusion in the President's Hotline.

(6) **Resolution #7—Confidentiality of Medical Information and Resolution #8—Unauthorized Release of Medical Information . . .** Referred these Resolutions to legal counsel for study and report back to the Board.

(7) **Resolution #9—Certification of Review Organizations . . .** Was referred to the Council on Legislation for development of appropriate legislation.

(8) **Resolution #10—Remove Alleged Birth-Related Neurological Injuries from Tort Law . . .** Agreed to withhold action pending receipt of a report on the study being conducted by the Medical Inter-Insurance Exchange of New Jersey.

(9) **Resolution #11—Telephone Information . . .** Was referred to legal counsel for study and report back to the Board.

(10) **Resolution #19—Physician Notification of Proposed Medicare Changes . . .** Directed that an appropriate letter be sent to the Health Care Financing Administration to

accomplish the action of this Resolution.

(11) **Resolution #21E—Medicare Deductibles and Co-Payments; Resolution #1—Freedom of Choice for Residency Program Directors; Resolution #13—Foreign Medical Graduates; and Resolution #16—Equality of Testing Foreign Medical Graduates . . .** Referred these Resolutions to the AMA Delegation for preparation of appropriate resolutions to be introduced to the AMA House of Delegates.

(12) **Resolution #15—Emergency Medical Services for New Jersey . . .** Was referred to the Committee on Emergency Medical Care for study and report back to the Board.

Unfinished Business . . .

(1) **PRO Contract . . .** Voted to file the letter from Dr. Kingsley requesting the support of MSNJ to accompany PRO's current bid for the New Jersey peer review contract.

New Business . . .

(1) **Resignation of Dr. Primich . . .** Expressed appreciation for Dr. Primich's service as chairman of the Council on Public Relations, upon his resignation.

(2) **Report of 1988 Annual Meeting . . .** Noted that the 1988 Annual Meeting was successful.

(3) **New Jersey Society for Medical Assistants . . .** Noted that a letter of commendation will be directed to the New Jersey Society of Medical Assistants for their voluntary staffing of the message center during the 1988 Annual Meeting.

(4) **AIDS Symposium . . .** Noted that the AIDS symposium was well received and the education program at future annual meetings will be videotaped and made available at cost to component medical societies.

(5) **Request for Endorsement of AIDS Study . . .** Referred the letter from Jack Elinson, Ph.D., requesting MSNJ endorsement of a proposed AIDS telephone survey to be conducted in New Jersey for educational purposes, to the Task Force on AIDS for evaluation and report back to the Board.

(6) **Board Workshop on Medical Inter-Insurance Exchange of New Jersey . . .** Authorized the president to collaborate with Dr. Mineur in the development of a one-day or half-day program for MIENJ to educate members about the company and its function.

(7) **Arthur Krosnick, M.D., Editor . . .** Noted a Resolution honoring Dr. Krosnick upon his resignation as editor of *NEW JERSEY MEDICINE*.

(8) **Resolution from Sussex County Medical Society—DRGs . . .** Referred a Resolution calling for MSNJ to request the New Jersey Department of Health to review the DRG assignments for certain categories of illness found to lack adequate reimbursement to hospitals and physicians to the Committee on Utilization Review Systems for consideration.

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Category: (Please check one)

☐ Member, MSNJ ☐ Subscriber, NJ Medicine

☐ Other _____

Name _____

Old Address _____

City _____ State _____ Zip _____

New Address _____

City _____ State _____ Zip _____

UMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

This spring, UMDNJ conferred more than 700 advanced degrees and certificates in the health sciences professions at its 15th annual commencement exercises, held at the Garden State Arts Center in Holmdel.

Commencement highlights included remarks by Philip K. White, vice-chancellor of the Department of Higher Education; and the awarding of honorary degrees to Dr. Albert Sabin, famed developer of the oral polio vaccine; Dr. June Jackson Christmas, founder of the Harlem

Rehabilitation Center and the first black president of the American Public Health Association; Dr. Marshall W. Nirenberg, a Nobel Prize recipient for advances in genetic research; and Wesley J. Howe, chairman of the board and chief executive officer of Becton Dickinson and Company.

In addition, UMDNJ presented distinguished alumnus awards to Anthony Volpe, D.D.S., M.S., a 1960 graduate of the charter class of the former Seton Hall University College of Dentistry, which now is UMDNJ-New Jersey Dental School; and Anthony DeMaria, M.D., a 1968 graduate of UMDNJ-New Jersey Medical School.

Included among the degrees and certificates presented were 17 masters of public health degrees to the third graduating class of the combined program between UMDNJ and Rutgers University; their degrees feature the seals of both institutions.

Medical degrees were awarded by school: UMDNJ-New Jersey Medical School (Newark), 165 M.D. degrees; UMDNJ-Robert Wood Johnson Medical School (Piscataway/New Brunswick), 101 M.D. degrees; UMDNJ-Robert Wood Johnson Medical School at Camden, 44 M.D. degrees; and UMDNJ-School of Osteopathic Medicine (Camden/Stratford), 45 doctor of osteopathy (D.O.) degrees.

Other degrees included UMDNJ-New Jersey Dental School (Newark), 73 doctor of dental medicine (D.M.D.) degrees; and UMDNJ-Graduate School of Biomedical Sciences (Newark), 12 Ph.D. degrees and one master of biodental science degree. In addition, 77 students received joint graduate degrees from Rutgers University and the UMDNJ-Graduate School of Biomedical Sciences (Piscataway), including 31 M.S. and 46 Ph.D. degrees.

The UMDNJ-School of Health Related Professions (Newark) awarded 188 certificates in a variety of health professions, including cytotechnology, nursing education, nurse-midwifery, dental hygiene and dental assisting, medical technology, physical therapy, and radiography. Certificates also were presented in programs operated jointly by the school and other educational institutions in respiratory therapy, toxicology, EMT-paramedic training, and phy-

sician's assistant. UMDNJ's physician's assistant program is rated the best in the nation, but graduates must leave the state to practice because New Jersey does not recognize the profession.

Visitors to our Newark campus are invited to drop by the Smith Library to view a display of memorabilia on the "Pioneer Women Physicians of New Jersey."

The exhibit is being mounted through December in celebration of the inauguration of Palma Formica, M.D., as the first woman president of the Medical Society of New Jersey. It focuses on 20 pioneer women, from the years 1830 to 1988, whose wide variety of achievements have made history in New Jersey.

Five living women are included in the exhibit. In addition to Dr. Formica, who is associate professor of clinical family medicine at our Robert Wood Johnson Medical School, they are: Drs. Laura Morrow, former American Medical Women's Association (AMWA) president and the first woman president of the New Jersey Psychiatric Association; Christine Haycock, associate professor of surgery at UMDNJ-New Jersey Medical School, former AMWA president and the first woman to transfer from the Nurse Corps to the Army Medical Corps; Eva Topkin Brodtkin, the first woman dermatologist in New Jersey, and the first woman president of the New Jersey Dermatologic Society; Mathilda Vaschek, the first woman medical director of a corporation in New Jersey (E.R. Squibb & Sons Pharmaceuticals, 1952) and the first woman chairman of the Occupational Medical Society of New Jersey; and E. Mae McCarroll, the first black woman appointed to Newark City Hospital and former president of the New Jersey State Medical Association.

New Members

The Medical Society of New Jersey would like to welcome the following new members:

Atlantic County

Jan K. Astin, M.D., Mays Landing
Mosses Bairamian, M.D.,

Absecon Highlands
Naim Nazha, M.D., Atlantic City
Antoine Sayegh, M.D., Margate
David B. Slotoroff, M.D., Pomona

Bergen County

John B. Amodio, M.D., Teaneck

Marcelo F. Batkis, M.D., Paramus
Mark Berman, M.D., River Edge
John Blebea, M.D., Maywood
John E. Braun, D.O., Hillsdale
Alan J. Briker, M.D., Harrington Park
Michael C. Distefano, M.D., Hackensack
Michael G. Faust, M.D., Wyckoff
Mark D. Goldberg, M.D., Wayne
Chang H. Kang, M.D., Woodcliff Lake
Kathleen M. Kelly, M.D., Hackensack
Michael B. Kesselbrenner, M.D.,

Fair Lawn

Jeffrey Kocher, M.D., Englewood
Gregory J. Mulford, M.D., Teaneck
Ruth J. Schulze, M.D., Ridgewood
Philip O. Roux-Lough, M.D., Hackensack
Richard M. Schwab, M.D., Teaneck
Dovelet Shashou, M.D., Fort Lee
Diane G. Verga, M.D., Hawthorne
Martin R. Weinberg, M.D., Teaneck

Burlington County

Gerald C. De Tata, M.D., Tabernacle
Susan D. Entmacher, M.D., Mount Laurel
Phillip Glass, M.D., Moorestown
James M. Levett, M.D., Browns Mills
G. Tom Morea, M.D., Marlton
David M. Murphy, M.D., Browns Mills
Parveen Rashid, M.D., Mount Holly

Camden County

Mary Ann M. Ager, M.D., Cherry Hill
Steven A. Ager, M.D., Cherry Hill
James B. Alexander, M.D., Camden
Cleo J. Froix, M.D., Voorhees
George A. Knod, D.O., Camden
Ronald I. Leberman, M.D., Blackwood
Bryan J. McIntyre, D.O., Voorhees
Thomas J. Sergi, M.D., Haddonfield
Michael I. Sobel, D.O., Cherry Hill
Michael J. Yaros, M.D., Cherry Hill
Lee H. Yasgur, M.D., Cherry Hill

Cumberland County

John C. O'Donnell, Jr., M.D., Millville

Essex County

Bernard J. Beute, M.D., West Orange
Stephen M. Blumberg, M.D.,
New York, NY
Gregory B. Carson, M.D., Belleville
Robert C. Dorman, M.D., Garfield
Esther B. Fox, D.O., Belleville
Reginia H. Friedman, M.D., Montclair
Thomas E. Helbig, M.D., South Orange
Alan S. Helfman, M.D., Elizabeth
Anne Kublin, M.D., West Orange
John M. Murphy, M.D., Maplewood
Anita M. Ortega-Jongco, M.D., Irvington
Dennis P. Quinlan, M.D., South Orange
Earl V. Sandor, M.D., Bloomfield
Aba M. Simmonds, M.D., Irvington

Gloucester County

Bruce J. McGann, M.D., Pitman

Hudson County

Ira M. Brooks, M.D., Jersey City

Hunterdon County

Henry C. Allen, M.D.,
Upper Black Eddy, PA
Susan M. Bauman, M.D., Milford
Suzanne Holdcraft, M.D., Hopewell
David R. Polizzi, M.D., Flemington
Peter S. Pyatak, M.D., Flemington
Bradley L. Rosenberg, M.D., Flemington
Roberta L. Scherr, M.D., Flemington
Deborah A. Shalders, M.D., Perkasia, PA

Mercer County

Richard Levandowski, M.D., Pennington
Madeline M. Manzione, M.D.,

Lawrenceville

Alicia S. Peller, M.D., Allentown

Middlesex County

Sushma Agarwal, M.D., Edison
Maria Auletta, M.D., New Brunswick
Yitzhak Berger, M.D., New Brunswick
Robert R. Blank, M.D., East Brunswick
Julio Hip-Flores, M.D., Piscataway
Karen A. Hoebich, M.D., Edison
Otto B. Jorgensen, Jr., M.D.,
New Brunswick

Joseph S. Lombardi, M.D., Edison
Robert M. Lombardi, M.D., Edison
Charles F. Martinson, M.D., Kingston
Meena S. Murthy, M.D., Somerset
James C. Salwitz, M.D., New Brunswick
Ram Sambandan, M.D., East Brunswick
Teresa M. Schaer, M.D., New Brunswick
Jeffrey H. Schiff, M.D., North Brunswick
Wayne E. Steinbeck, M.D., Metuchen
Edward C. White, M.D., New Brunswick
Christopher C. Wright, M.D., Piscataway
Michael A. Zatina, M.D., New Brunswick
Kenneth J. Zemanek, M.D., Piscataway

Monmouth County

John P. DeTullio, M.D., Englishtown
Paul M. Friedman, M.D., Manasquan
Mark T. Kircher, M.D., Monmouth Beach
Eric J. Michael, M.D., Little Silver
Paul C. Royce, M.D., Long Branch
Ronald I. Rubinstein, M.D., Neptune
Stephen J. Swartz, M.D., Middletown
Albert A. Tedeschi, M.D., Tinton Falls

Morris County

Victor M. Amato, M.D., Lake Hopatcong
Craig L. Bissinger, M.D., Parsippany
Douglas P. Cutillo, M.D., Stanhope
Joel A. DeLisa, M.D., West Orange
Carey Dolgin, M.D., Morristown
Unjeria C. Jackson, M.D., Morristown
Alan L. Kenwood, M.D., Morristown
Barry D. Weinreb, M.D., Morristown
Larry P. Weinstein, M.D., Morristown

Ocean County

Robert B. Edelmann, Jr., M.D., Lakewood
Edward L. Hedaya, M.D., Toms River
Thomas P. Lynch, M.D., Toms River

Sangita D. Nagpal, M.D., Brick
John S. O'Shea, M.D., Point Pleasant

Passaic County

Louise Alborno, M.D., Clifton
William D. Davidson, M.D., Clifton
Bartholomew F. Natoli, M.D., Clifton
Niranjankumar K. Parekh, M.D.,
Fair Lawn
Medhat N. Raouf, M.D., Ringwood

Salem County

Thomas F. Weir, M.D., Deepwater

Somerset County

Susan B. Arlen, M.D., Bridgewater
Joseph M. Kasparek, Jr., M.D.,
Somerville
Scott P. Keil, M.D., North Plainfield
Lynn M. Sutley-Hartmann, M.D.,
Hillsborough

Sussex County

M. Nicolai Nielsen, M.D., Sparta

Union County

James V. Agresti, D.O., Kenilworth
Joseph F. Altongy, M.D., Westfield
Julie Celeberti, M.D., Warren
Elizabeth A. Delaney, M.D., Summit
Amelia A. Erickson, M.D., Basking Ridge
Jordan S. Fersel, M.D., Springfield
Beverly Friedlander, M.D., Westfield
Alan F. Goldstein, M.D., Clark
Madhu B. Goyal, M.D., Plainfield
Craig J. Hart, M.D., Livingston
David S. Hoffman, M.D., Summit
Stephen G. Hurst, M.D., Plainfield
Orsolya M. Pogany, M.D., Martinsville
Yulius H. Poplyansky, M.D., Roselle Park
Mark S. Simko, M.D., Newark

Warren County

Ramakumar V. Rayasam, M.D.,
Phillipsburg
Atilio R. Roscher, M.D., Easton, PA

Physicians Seeking Location in New Jersey

**The following physicians have written
to the Executive Offices of MSNJ seek-
ing information on possible opportuni-**

**ties for practice in New Jersey. The in-
formation listed below has been sup-
plied by the physicians. If you are
interested in any further information
concerning these physicians, we sug-
gest you make inquiries directly to
them.**

ANESTHESIOLOGY—Kenneth Lum,
M.D., 7240 Twin Eagle Lane, Fort
Myers, FL 33912. Downstate 1985.
Board eligible. Available.

CARDIOLOGY—Donald G. Rubenstein,
M.D., 1037 3rd St., #303, Santa
Monica, CA 90403. Louisiana 1980.
Board eligible. Group or partnership.
Available August 1988.

DERMATOLOGY—Cheryl S. Citron,
M.D., 885 Sussex Rd., San Marino, CA
91108. Miami 1984. Board eligible.
Group, partnership, solo. Available.

ENDOCRINOLOGY—Robert P. Castel-
lucci, M.D., 3509 Kensington Ave., #3,
Richmond, VA 23221. St. George's
1982. Board eligible. Partnership or
group. Available September 1988.

FAMILY MEDICINE—John Travers,
M.D., 14225 Kendra Way, Poway, CA
92064. UMDNJ 1982. Group or HMO.
Available August 1988.

INTERNAL MEDICINE—Marc Hanfling,
D.O., 26 Glen Lane, Cherry Hill, NJ
08002. New York College 1981. Also,
cardiology. Board certified. Board
eligible (CARD). Group, partnership,
solo. Available.

Lalitha B. Iyer, M.D., 84 Hempstead
Dr., Somerset, NJ 08873. Madras
(India) 1980. Board eligible. Group,
partnership, emergency room. Avail-
able.

Joseph T. Wayne, M.D., 106 Elmwood
Dr., Prudenville, MI 48651. SUNY-Buf-
falo 1982. Also, pediatrics. Board
eligible. Board certified (PED). Also,
pediatrics. Group, partnership,
academic. Available October 1988.

PEDIATRICS—Linda York-Chance, M.D.,
435 East 70th St., New York, NY
10021. Connecticut 1985. Board eli-
gible. Clinic or emergency room. Avail-
able.

Iraj Modarai, M.D., 40 Cherry Hill,
Springfield, VT 05156. Tabriz (Iran)
1956; Polyclinic 1963. Board certified.
Clinic, emergency, salary. Available.

Joseph T. Wayne, M.D., 106 Elmwood
Dr., Prudenville, MI 48651. SUNY-Buf-
falo 1982. Also, internal medicine.
Board certified. Board eligible (IM).
Group, partnership, academic. Avail-
able.

PSYCHIATRY—Jozsef Telkes, M.D., c/o
John Black, 3901 Crosswicks-Hamilton
Square Rd., Robbinsville, NJ
08691. Pecs (Hungary) 1978. Board
certified. Group or research. Available
September 1988.

SURGERY—Andrea Resciniti, M.D., 4
Duncannon Ave., Apt. 9, Worcester, MA
01604. Hahnemann 1983. Board eli-
gible. HMO, multispecialty, group,
single specialty group. Available.

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Medical Society of New Jersey
Two Princess Road
Lawrenceville, NJ 08648

The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization for further information.

This list is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, The Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the UMDNJ Office of Continuing Medical Education. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

September

- 27 **NJSSA—General Membership Meeting**
6-10 P.M.—Ramada Inn, Clark (NJSSA)

CARDIOLOGY

September

- 28 **Advanced Cardiac Life Support**
6 P.M.—Freehold Area Hospital, Freehold
(Freehold Area Hospital)

DERMATOLOGY

September

- 6 **Dermatological Society of New Jersey**
7-10 P.M.—Schering-Plough Corporation, Kenilworth
(Dermatological Society of New Jersey)
- 21 **Dermatology Conferences**
6-9 P.M.—Rutgers Community Health Plan, 57 U.S. Highway 1, New Brunswick
(UMDNJ)
- 21 **Practice Management and Various Modalities of Treatment**

1-2 P.M.—West Hudson Hospital, Kearny
(West Hudson Hospital)

MEDICINE

August

- 10 **AIDS Update**
8-9 A.M.—Southern Ocean County Hospital, Manahawkin
(AMNJ)
- 12-13 **4th Annual Reunion of the Maulana Azad Medical College**
10 A.M.-12:30 P.M.—Caroussel Hotel and Resorts, Ocean City
(Maulana Azad Medical College)
- 18 **Functional Assessment of the Elderly**
2-3 P.M.—J.E. Runnells Hospital of Union County, Berkeley Heights
(AMNJ)

September

- 2 **Clues to the Diagnosis of Environmental Lung Disease**
9-10 A.M.—St. Francis Medical Center, Trenton
(AMNJ)
- 6 **Superior Vena Cava Syndrome**
7-8 P.M.—West Hudson Hospital, Kearny
(West Hudson Hospital)
- 6 **Cranio-Facial Abnormalities**
8:30-9:30 A.M.—Newark Beth Israel Medical Center, Newark
(Newark Beth Israel Medical Center)
- 8 **Importance of Accurate, Adequate, and Timely Charting in the Medical-Legal Environment of Today**
11 A.M.-noon—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and Medical Center)
- 12 **AIDS**
7-8 P.M.—Wallkill Valley General Hospital, Sussex
(AMNJ)
- 14 **Clues to the Diagnosis of Environmental Lung Disease**
12 noon-1 P.M.—St. James Hospital, Newark
(AMNJ)
- 14 **New Physician Program**
8 A.M.-4:30 P.M.—MSNJ Headquarters, Lawrenceville
(MIENJ)
- 16 **Clues to the Diagnosis of Environmental Lung Disease**
8:30-9:30 A.M.—United Hospitals Medical Center
(AMNJ)
- 19 **Role of Intraoperative Cholangiogram**
8-9 A.M.—West Hudson Hospital, Kearny
(West Hudson Hospital)
- 22 **Thyroid Diseases**
7:30-8:30—Atlantic City Medical Center, Atlantic City
(AMNJ)
- 23 **Clues to the Diagnosis of Environmental Lung Disease**
12 noon-1 P.M.—Freehold Area Hospital
(AMNJ)

- 24 **Alternative Career Choices**
9 A.M.—New Jersey Medical School, Newark
(UMDNJ)
- 24-26 **Seventh Annual Advances in Pain Management**
8 A.M.—Vista Hotel, New York City
(UMDNJ)
- 26 **Clues to the Diagnosis of Environmental Lung Disease**
11:30-12:30 P.M.—East Orange General Hospital, East Orange
(AMNJ)
- 27 **Snake Bites**
8-10 P.M.—The Englewood Club, Englewood
(Englewood Surgical Society)
- 30 **Trauma Rehabilitation**
11:30-12:30 P.M.—St. Lawrence Rehabilitation Center, Lawrenceville
(St. Lawrence Rehabilitation Center)

OBSTETRICS/GYNECOLOGY

September

- 28 **Perinatal Care and the Working Woman**
8 A.M.-3 P.M.—Holiday Inn, Jamesburg
(Perinatal Association of New Jersey)

ONCOLOGY

September

- 8-10 **Second Conference on Radioimmunodetection and Radioimmunotherapy of Cancer**
8 A.M.-6 P.M.—Scanticon, Princeton
(UMDNJ)
- 15 **Head and Neck Section**
6-9 P.M.—The Manor, West Orange
(AMNJ)
- 15 **Tumor Board Conferences**
12 noon-1 P.M.—Newcomb Medical Center, Vineland
(Newcomb Medical Center)

PEDIATRICS

- 28 **The Dysmorphic Child**
9 A.M.-3 P.M.—Children's Specialized Hospital, Mountainside
(Children's Specialized Hospital)

PSYCHIATRY

September

- 1 **Research in Treating Alcoholism**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)
- 8 **Alcoholic Family**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)
- 15 **Electroconvulsive Therapy**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)
- 28 **Ethics and Clinical Psychiatry**
9 A.M.-5 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)
- 29 **AIDS: Psychiatric Manifestations**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

Autoimmune Rheumatic Disease; Clinical Neuroimmunology; Food Allergy and Intolerance; The Merck Manual of Diagnosis and Therapy; Textbook of Immunology

Autoimmune Rheumatic Disease

John Morrow, Ph.D., David Isenberg, M.D. Boston, MA, Blackwell Scientific Publications, 1987. Pp. 324.

The text attempts to provide systematic and succinct updates on various systemic rheumatic disorders. The text integrates the basic science of the immune system as developed from animal models with human disorders. *Autoimmune Rheumatic Disease*, with its case presentations interspersed throughout the book, is better suited as a brief introductory text to these disorders for clinicians who wish to broaden their diagnostic capabilities.

The text is written clearly and illustrated to introduce physicians to the clinical aspects of these disorders with an added emphasis on their possible pathogenesis. Historical perspectives of each autoimmune process provide an excellent background to appreciate many facets of these disorders. Case presentations are interspersed throughout the textbook and can be viewed as a valuable learning reinforcement, but as unnecessary interruptions by others. The reference sections are extensive and current. Therapeutic intervention is delivered in a brief

fashion based on experimental approaches of therapy. The emphasis on animal models and experimental approaches to therapy provides an intuitive position with thought-provoking treatments that may be able to be applied to other disorders physicians may encounter in the future.

Overall, the text provides a clear-cut presentation of clinically useful immunological assays that commonly are used for these disorders; however, the text is too brief to provide any sort of meaningful review for rheumatologists.

Leonard Bielory, M.D.

Clinical Neuroimmunology

J.A. Aarli, W.M.H. Behan, and P.O. Behan, (eds). Boston, MA, Blackwell Scientific Publications, 1987. Pp. 531.

Extensive advances in the knowledge of the interaction of the immune and nervous systems have been made over the past several years leading to a separate entity known as neuroimmunology. Initially, this was the domain of the researcher with primary emphasis placed on the effects of vaccines and immunization on the nervous system of laboratory animals. However, it has become obvious that an understanding of the complex interactions of the immunological processes with the nervous system is needed for the advancement of clinical neurology.

This understanding of techniques and findings from bench to the bedside has offered the etiopathogenesis of prior unknown neuropathological disorders. This fundamental knowledge is needed for the diagnosis and for the advanced treatment of many of these neurological conditions.

This text apparently has been organized for the practicing clinician. The initial chapters provide the immunological background for the immunopathogenesis of many of the disorders. The leading international authorities on various aspects of "neuroimmunology" have been brought together in this text in order for the clinician to develop a fundamental framework of the neurological disorders. The illnesses discussed are not only those that primarily affect the central nervous sys-

tem but also systemic illnesses such as vasculitis, e.g. systemic lupus, erythematosus, and neoplasia where secondary, immune-mediated effects on the brain, peripheral nerves, and muscles are involved. A major emphasis is placed on various features associated with viral infections of the central nervous system and the various presentations that a viral infection may take. Controversy in the pathogenesis of suspected autoimmune disorders such as multiple sclerosis clearly are presented with reviews of other demyelinating disorders of the central and peripheral nervous systems, myasthenia gravis, and motor neuron disease. Unfortunately, there is an absence of a chapter directed towards the neuroimmunological complications of the acquired immunodeficiency syndrome. However, this does not detract from the excellently presented, organized, and well-written text. The references given at the end of each chapter reflect information available through 1986.

Overall, although primarily directed for clinical neurologists, the book also will appeal to other clinicians such as neuropathologists, psychiatrists, neurosurgeons, and any researcher interested in the field of neuroimmunology. This text provides a vital link for those interested in bench research as it reflects on the care of neurological conditions.

Leonard Bielory, M.D.

Food Allergy and Intolerance

Jonathan Brostoff, and Stephen J. Challacomb, M.D. Philadelphia, PA, Bailliere Tindall, 1987. Pp. 1,056. (\$125)

Food allergy is one of the last open areas of immunology in which there is considerable controversy regarding symptoms caused by "foods" and various methods used to diagnose and treat them. However, advances over the past ten years utilizing well-designed placebo-controlled clinical trials have helped elucidate immunologic, metabolic, and pharmacological reactions that identify food allergy or intolerance. In the past, allergists classically have defined "food allergy" in similar ways as to the classical allergic symptoms such as urticaria, asthma, anaphylaxis, and gluten-sensitive enteropathy.

However, with various unexplained behavioral, psychiatric, neurologic, and metabolic symptoms associated with the ingestion of various food-stuffs, some individuals consider these as "hypersensitivity" responses and consider that the classical symptoms listed above represent only a fraction of the total food allergy scenario.

In this text, the editors intentionally present both orthodox versus unorthodox viewpoints. They also state in their preface, "There is no suggestion that, because we have invited particular authors to contribute to our book, we necessarily agree with their view. Occasionally the reverse is true!" However, for the uninitiated practicing physician interested in the field of food allergy this presents a problem, since he unwittingly may accept the unorthodox views. This may be corrected if a person is willing to pursue the cited references. Even if one does so, it still is quite difficult to differentiate between speculation and scientific fact.

The text has five parts: 1—basic mechanisms; 2—food, components and their reactions; 3—end organ, effects, 4—diagnosis of food allergy and intolerance; and 5—treatment of food allergy.

Parts 1, 2, and 3 are well-written reviews of mucosal immunity and physiology on the cellular level and extending to the pharmacological and physiological effects on various organs. However, the last two parts of the book do not maintain the scientific caliber of the first two parts and integrate unorthodox as well as orthodox modes of diagnosis and treatment without clearly differentiating between the two.

Overall, the book is a well-written and versed text which complements the 1984 NIH publication (#84-2442) titled *Adverse Reactions to Food* published by the American Committee of Allergy and Immunology and the National Institute of Allergy and Infectious Diseases. The text presents a comprehensive, though not always critical, review for physicians and warrants reading by anyone interested in the area of food allergy with a caveat that unorthodox practices are integrated in

the text for completeness, and are not necessarily to be used in the clinical practice of medicine.

Leonard Bielory, M.D.

The Merck Manual of Diagnosis and Therapy, 15th Edition

Robert Berkow, M.D., (ed). Rahway, NJ, Merck & Co., Inc., 1987. Pp. 2,696.

"The first edition of the *Merck Manual of Materia Medica* was dated 1899. It contained 262 pages and was expressly designed to meet the needs of the general practitioners in selecting medications, noting that memory is treacherous..." Thus, starts the foreword to this latest edition, almost 90 years since its ancestor was born, and now containing ten times as many pages!

The *Merck Manual* of today continues to try to meet the needs of the physician to remember, recall, review, and relearn the volumes of information he needs, to treat his patients and to answer questions asked of them or of his colleagues, or of his students. The information presented here is in its typical compact form—easily managed, handled, and reviewed.

A total of 269 authors were engaged to work and complete the 15th edition, under the leadership of Robert Berkow, M.D., senior director of medical literature of the Merck, Sharp & Dohme Research Laboratory. The internal and external review procedures of every subject discussed and every treatment suggested, were repeated at least six times, to assure accuracy.

As in previous editions, disorders are organized according to organ system, or on basis of etiology or on basis of discipline. This edition has an extra 114 pages over the previous edition, with the inclusion of new subject matter pertaining to diagnostic and therapeutic procedures in gastroenterology, AIDS, reproductive endocrinology, oncology, management of severe and chronic pain, hyperbaric oxygen therapy, special considerations in the drug treatment of infants, children, and the management of geriatric problems.

It is difficult to believe that health service attendants can do better than using a *Merck Manual of Diagnosis and Therapy, 15th Edition* at their side for a timely review of pertinent information on any medical problems facing patients.

As in the past history of previous editions, the *Merck Manual* reader acceptance always has been favorable and it is believed this 15th edition also will be accepted.

Harry M. Poppick, M.D.

Textbook of Immunology. An Introduction to Immunochemistry and Immunobiology. Fifth Edition.

James T. Barrett, Ph.D. St. Louis, MO, C.V. Mosby Company, 1988. Pp. 455.

This is one of many textbooks on immunology written for a broad audience, more specifically for students of medicine and the paramedical sciences and those physicians searching for a basic text with clinical implications. Even though several excellent and extensive immunological reviews are available, they normally are too focused and too detailed for a clinician inexperienced in the field of immunology. The text provides a broad base and discussions on various items with additional readings without the necessity of a voluminous, commonly outdated bibliography. In addition, a brief appendix is included for those who are just entering and learning about the field of immunology. Included within the chapters are special situations in which a particular item is discussed further with possible clinical relevance. In addition, there are some chapters with "citation classics" in which outstanding citations are brought to the reader's attention and discussed. This appears to highlight important events in the evolution in the field of immunology.

In summary, the text is truly an introductory one for students of medicine and the paramedical sciences or those physicians who are uninitiated to the field of immunology. Leonard Bielory, M.D.

***Drs. Elias; Evans;
Jackson; Keller; Lewis;
Lucarella; Rosenthal;
Rothfleisch; Santor;
Speirs; Wessel;
Wiesler; Zuravin***

Dr. Elmer J. Elias

Specialist in physical medicine and rehabilitation, Elmer John Elias, M.D., died March 6, 1988, at the age of 83. A native of Trenton, and a life-long area resident, Dr. Elias received his medical degree from Jefferson Medical College of Philadelphia, in 1928. From 1929 to 1962, he maintained a private practice in Trenton. Affiliated with Mercer Medical Center, Dr. Elias served for many years as chief of the Department of Physical Medicine and Rehabilitation. In addition, he was public health officer for the city of Trenton. A diplomate in physical medicine and rehabilitation, Dr. Elias was a member of many organizations, including: the New Jersey Society of Physical Medicine, serving as president; the Association of Military Surgeons; the American Public Health Association; the New Jersey Health Association; the Academy of Medicine of New Jersey; the Royal Society of Health, London; the College of Physicians of Philadelphia; the American Congress of Physical Medicine and Rehabilitation; the American Medical Association; and our Mercer County component. An active member of the Medical Society of New Jersey, Dr. Elias was chairman of the Society's Committee on Rehabilitation, and a member of its Council on Public Health. He was a part-time instructor at Jefferson Medical College, and

was a consultant on physical medicine for the United States Postal Service. During World War II, Dr. Elias served in the United States Army medical corps, attaining the rank of major. In 1978, he received the Medical Society of New Jersey's Golden Merit Award, for 50 years of service as a physician.

Dr. H. Walter Evans, Jr.

Retired anesthesiologist H. Walter Evans, Jr., M.D., died on February 17, 1988, at the age of 65. Dr. Evans attended Hahnemann Medical College and Hospital, Philadelphia, receiving his medical degree in 1947. He was affiliated with Jersey Shore Medical Center, and was a member of our Monmouth County component and of the American Medical Association.

Dr. George H. Jackson

General practitioner George Harold Jackson, M.D., 83, died on July 8, 1987, in Port Perry, Ontario, Canada, where he had been retired since 1966. A native of Ontario, Dr. Jackson received his medical degree from the Faculty of Medicine, University of Toronto, Canada, in 1928. After maintaining a family practice in Union, Dr. Jackson was staff physician for Western Electric, Kearny, until his retirement. For 50 years as a physician, Dr. Jackson received MSNJ's Golden Merit Award in 1978. He was a member of our Essex County component and of the AMA.

Dr. Earl B. Keller, Jr.

Earl Blaine Keller, Jr., M.D., an obstetrician-gynecologist with the West Jersey Hospital System for 34 years, died on February 14, 1988, at the age of 74. Born in Philadelphia, Dr. Keller received his medical degree in 1939 from the University of Pennsylvania School of Medicine, Philadelphia. In 1946, after serving with the United States Air Force hospital unit in the China-India-Burma zone during World War II, Dr. Keller joined West Jersey Hospital. He maintained this affiliation until his retirement in 1980. Dr. Keller was selected chairman of the hospital's Department of Obstetrics and Gynecology (1960-1980), was elected president of the professional staff (1960), and was elected to the Board

of Trustees (1962). From 1980 to 1984, Dr. Keller was a surgical assistant at Zurbrugg Memorial Hospital, in Riverside. A diplomate in obstetrics and gynecology, Dr. Keller was a fellow of the American College of Obstetricians and Gynecologists, and of the American College of Surgeons, and was a member of our Camden County component and of the AMA.

Dr. Alexander Lewis

Former Rahway general practitioner, Alexander Lewis, M.D., 77, died on March 3, 1988. Born in Poland, Dr. Lewis attended Perugia University, Italy, where he received his medical degree in 1936. As well as maintaining a private practice in Rahway, Dr. Lewis was affiliated with Rahway Hospital, and was a member of our Union County component. Dr. Lewis received the Golden Merit Award in 1986.

Dr. Joseph A. Lucarella

Trenton cardiologist Joseph Anthony Lucarella, M.D., 55, died on March 4, 1988. A Trenton native, Dr. Lucarella was graduated from Jefferson Medical College of Philadelphia, Pennsylvania, in 1957. He maintained a private internal medicine practice in Trenton before beginning a cardiology fellowship at Hahnemann Medical College, Philadelphia. In 1966, he returned to Trenton to practice cardiology at St. Francis Medical Center, serving as chairman of the Cardiac Care Unit Committee, and as a member of the Quality Assurance Committee. As well as being an assistant professor in clinical medicine at Hahnemann Hospital, Dr. Lucarella also was affiliated with Helene Fuld Medical Center in Trenton. Dr. Lucarella was a member of our Mercer County component and of the American Medical Association.

Dr. Arnold J. Rosenthal

Retired general practitioner Arnold Jay Rosenthal, M.D., died on February 25, 1988, at the age of 77. A native of Newark, Dr. Rosenthal received his medical degree from the University of Zurich, Switzerland, in 1935. Affiliated with Newark Beth Israel Medical Center, Dr. Rosenthal was a member of our Essex County component and of the American Medical Association. In 1985, he re-

ceived the Medical Society of New Jersey's Golden Merit Award, for 50 years of medical practice.

Dr. Sheldon Rothfleisch

Plastic surgeon Sheldon Rothfleisch, M.D., 49, died on April 11, 1988, after more than 15 years of practice in New Brunswick. Born in New York, Dr. Rothfleisch received his medical degree from the University of Buffalo, in 1964. A diplomate in both surgery and plastic surgery, Dr. Rothfleisch was a fellow of the American College of Surgeons and of the New York Academy of Medicine, and was a member of our Middlesex County component and of the AMA. A resident of East Brunswick for the past 20 years, Dr. Rothfleisch was affiliated with St. Peter's Medical Center and Robert Wood Johnson University Hospital, both in New Brunswick; UMDNJ-Robert Wood Johnson Medical School, Piscataway; John F. Kennedy Medical Center, Edison; Raritan Bay Medical Center, Perth Amboy; and The Medical Center at Princeton. From 1965 to 1971, he was a United States Air Reserve captain.

Dr. Daniel Santor

Family physician Daniel Santor, M.D., 77, died on April 10, 1988, after maintaining a private practice in Berlin from 1942 to 1986. Born in Philadelphia, Dr. Santor attended the Faculty of Medicine, University of Rome, Italy, where he received his medical degree in 1937. In addition to his Berlin practice, Dr. Santor was affiliated with the West Jersey Health System, Southern Division, Berlin. For many years, he was physician for Edgewood High School,

Winslow Township, and worked for Lucas Paint Company-Sherwin Williams, Gibbsboro, from 1945 until its closing. A member of our Camden County component and of the AMA, Dr. Santor received the Golden Merit Award in 1987.

Dr. Harold A. Speirs

A family physician in Audubon for 32 years, Harold Archer Speirs, M.D., died on February 6, 1988, at the age of 59. A native of Philadelphia, Dr. Speirs received his medical degree from Jefferson Medical College, Pennsylvania, in 1955. A year later, he opened a private practice in Audubon, maintaining this practice until November 1987. Active in his community, Dr. Speirs served as school physician for the Haddon Heights Baptist High School. He was a member of our Camden County component, of the AMA, of the American Academy of Family Practice, of the Christian Medical Society, of the American Heart Association, and of the American Association of Retired Persons. Dr. Speirs served as a sergeant in the United States Army from 1945 to 1947.

Dr. Edward J. Wessel, Jr.

Former chief of staff and surgery at Newton Memorial Hospital, Edward Joseph Wessel, Jr., M.D., died on January 14, 1988, at the age of 55. Born in Mt. Holly, Dr. Wessel received his medical degree from the University of Pennsylvania, Philadelphia, in 1958. A specialist in general and traumatic surgery, Dr. Wessel became affiliated with Wallkill Valley General Hospital, Sussex, as well as Newton Memorial Hospital. A diplomate in surgery, and a fellow of the

American College of Surgeons, Dr. Wessel was a member of our Sussex County component, of the American Medical Association, and of the Academy of Medicine of New Jersey. From 1959 to 1962, he attained the rank of captain in the United States Army medical corps.

Dr. Howard M. Wiesler

Retired prison physician Howard M. Wiesler, M.D., 88, died on March 3, 1988, in Mesa, Arizona. A native of Cedarburg, Wisconsin, Dr. Wiesler received his medical degree from the University of St. Louis, Missouri, in 1924. From 1924 to 1934, he maintained a private practice in Trenton. In 1934, Dr. Wiesler became resident physician and later, medical director at New Jersey State Prison, where he practiced until 1972. A member of the American Medical Association and of our Mercer County component, Dr. Wiesler received MSNJ's Golden Merit Award in 1974.

Dr. Meyer H. Zuravin

Lakewood and Toms River urologist Meyer Harry Zuravin, M.D., 80, died on February 9, 1988. Born in Brooklyn, New York, Dr. Zuravin attended the University of Maryland School of Medicine, Baltimore, where he received his medical degree in 1932. He became affiliated with Kimball Medical Center, Lakewood, and Community Memorial Hospital, Toms River. Dr. Zuravin was a fellow of the American College of Surgeons, and was a member of our Ocean County component and of the AMA. During World War II, he served in the Army medical corps as a major. In 1982, Dr. Zuravin received the Golden Merit Award.

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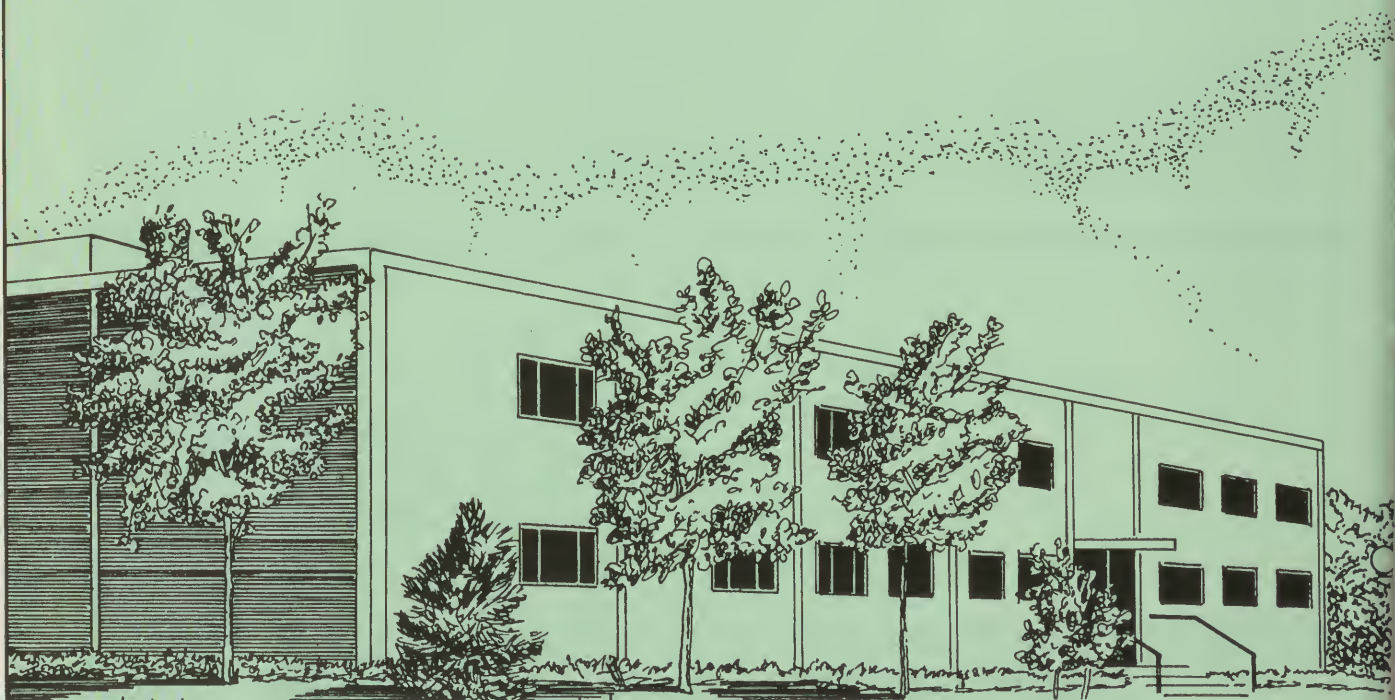


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1988 TRANSACTIONS

Medical Society of New Jersey



Transactions: 1988 House of Delegates

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1987 Transactions

The House of Delegates approved the Transactions of the 1987 Annual Meetings, as published in *NEW JERSEY MEDICINE*.

Action To Limit Debate

The House of Delegates, agreed, upon motion, that no one may speak more than once on any given subject except in rebuttal or by express permission of the House, and that floor time in each instance shall be limited to four minutes unless exception is made by the House.

Reports and Resolutions

Reports and resolutions and the actions, thereon, are included under the Reference Committee to which they were assigned. The House takes action only on the resolved sections of a resolution.

1988 HOUSE OF DELEGATES

**Medical Society of New Jersey
222nd Annual Meeting
April 28 – May 1, 1988**

REFERENCE COMMITTEE "A"

REPORTS

**President/Chairman of the Board of Trustees
Judicial Council
AMA Delegation
Executive Director
Committee on Long-Range Planning and Development
Committee on Physicians' Health
Board of Trustees' Item: X-ray Demonstration of
Chiropractic Subluxation
Resolutions #3, #4, #18, #20, #22E**

MEMBERS

**Bartholomew R. D'Ascoli, MD, Chairman
Shah M. Chaudhry, MD
Terry A. Johnston, MD
Andrew Kunish, MD
Manuel A. Rivas, MD
David J. Greifinger, MD, Alternate Member**

President/Chairman of Board of Trustees

HARRY M. CARNES, MD

(Reference Committee "A")

This has been a very active, exciting year at the Medical Society of New Jersey. Within a fortnight of my ascendance to the presidency, the Medical Society appeared before the Health and Human Resources Committee of the Assembly. With strong support from our general membership and reasoned responses to the committee members, we were able to defeat unanimously the onerous Mandatory Medicare Assignment Bill—2511.

The other major legislative victories have been: stalling of the physical therapy bill in the Assembly; stalling a bill to permit nurses to prescribe drugs; defeat of the optometric drug bill in the Senate; and passage in the Assembly of a bill precluding state agencies from creating licensed professions without specific legislative approval—specifically, physician assistants.

We were able to garner some tort reform measures, such as collateral sources, and joint and several liability, but were unable to get a vote on major tort reform in the Senate Judiciary Committee. Those bills pertained to structured settlements of large malpractice awards, and change in the statute of limitations. The failure of these reform measures was a bitter defeat, but we are going to reintroduce them and redouble our efforts.

It is my personal opinion that MSNJ possesses the talent, the resources, and, most importantly, the will to be a continuous major political force in this state. This is due in large part to the performance of JEMPAC, and the untiring efforts and superb leadership of Bill Ryan. At the present time, we have lines of communication open to all our elected (and to the major appointed) officials involved in health care in New Jersey.

The unexpected negative aspects of the State Commission of Investigation (SCI) Report released November 5, 1987, were frustrating at best. We were aware of, and had cooperated with, the SCI through our Physicians' Health Program. The professionally damaging aspect of this report was the subtle manner in which the SCI attempted to link physician malpractice and impairment with incompetence. This basic flaw undermines the credibility of the Commission.

In an attempt to defuse the issue, we chose not to formally respond to what was—at that time—a very negative media. Instead, we hired a very prominent attorney with excellent credentials: Judge Herbert J. Stern. We chose not to become involved in a prolonged legal battle through the courts, but to concentrate our efforts in the Legislature. Judge Stern has recommended to Senator Codey a proposal which will be fair to physicians and protect the public.

Medicaid reimbursement to physicians in this state could only be described as "obscene." However, we have been promised an increased fee schedule by Doctor Drew Altman, Commissioner of Human Services. He is to raise physician fees, and continue to revise the fee schedule yearly until it is equitable with the private sector. This is a tall order, but we have every confidence that Doctor Altman will maintain his word. Of course, legislative support will be required for such action. Our position looks promising at present.

Membership remains a continuing problem, and I see no end in sight. Despite strong efforts by my successor, problems remain. We must persist in our efforts to attract greater numbers of women and other minorities to membership in our Society.

The \$100 mandatory assessment for public relations voted by the 1987 House of Delegates remains with us. Approximately 75 percent of the membership has responded.

The "number one" topic and problem in medicine today is AIDS. I appointed Dr. Leon Smith to head the AIDS Task Force, to advise and educate the membership. A report will be presented to the House of Delegates at the Annual Meeting. The Task Force also has responsibility for the symposium scheduled for Sunday, May 1, 1988.

It has been my privilege to travel the state as your representative during the past 12 months. I have visited most of the counties, and have had multiple meetings with health care, legislative, and judicial leaders throughout the state. My heartfelt thanks to all who have worked on our committees, and to the staff for a magnificent job.

The Reference Committee recommends that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

Judicial Council

PAUL H. STEEL, MD, CHAIRMAN

(Reference Committee "A")

From official findings, the Judicial Council presents a summary of its operations and those of county judicial committees for the period May 1987 through March 1988:

By Judicial Committees

Complaints reported as disposed of	74
Alleging:	
Dissatisfaction concerning fees	43
Dissatisfaction concerning medical procedures	16
Unprofessional conduct	5
Dissatisfaction concerning professional ethics	10

By Judicial Council

Meetings held	2
Official communications acted upon	150
Appeal hearings requested	3
Appeal hearings granted	0
Formal opinions rendered	2

1. Opinion of the Judicial Council Concerning Physician Responsibility Regarding AIDS Patients (Adopted August 5, 1987). Physicians have a long tradition of caring for patients afflicted with infectious diseases with compassion and courage. Not everyone is emotionally able to care for a patient with AIDS. If a doctor is unable to care for a patient with AIDS, that doctor should ask to be removed from the case.

In those instances where a physician chooses to remove himself/herself from the care of an AIDS patient, it is that physician's responsibility to make alternative arrangements for the proper care of the patient.

While the Council recognizes the right of the physician to determine which patients he/she will serve, it does not believe that a categorical refusal to treat patients with AIDS is morally or ethically acceptable.

2. Opinion of the Judicial Council Concerning Ethical Procedures in Second Surgical Opinions (Adopted August 5, 1987). The Judicial Council has received a number of inquiries from members regarding our prior opinion, Ethical Procedures in Second Surgical Opinion Programs. We have reviewed the available literature including statements made by the AMA Judicial Council and the New Jersey Board of Medical Examiners.

We believe the following opinion presents the best approach for physicians and patients in New Jersey:

- A. If a request for a second opinion comes from another physician, the second opinion physician may offer only an opinion in writing to the referring physician.
- B. If a request for a second opinion comes from an insurance company, the second opinion physician may offer an opinion to the insurance company in writing.
- C. If a second opinion is requested by a patient or his guardian, the second opinion physician is obligated to the patient or guardian.
- D. A second opinion physician should have no pecuniary relationship with the referring physician.

In items A and B, if a patient, after consulting with a second opinion physician wishes to use the service of this second opinion physician, this may be done by written consent obtained from the physician or the insurance company requesting the second opinion.

It is considered unethical for a second opinion physician to assume the care of the patient in question unless the above circumstances are met.

3. **Appeal Hearings.** The Judicial Council has scheduled a meeting for review and discussion of the three requests for appeal hearings from findings of County Judicial Committees.

4. **Judicial Council Opinions.** The Judicial Council agreed that, since their inception, many of its official opinions, due to dramatic changes in the practice of medicine, are outdated and inappropriate. This Council, at this writing, is in the process of revising and amending its listing of official opinions and when completed this annotated revision will be forwarded to all County Judicial Committees.

5. **Rules and Regulations.** The *Rules & Regulations of the Judicial Council for the Processing of Grievances and Complaints* was amended and forwarded to all County Judicial Committees.

6. **Assisting Surgeons.** The Judicial Council has received a number of complaints regarding charges by assisting surgeons. The following informational statement was forwarded to all County Judicial Committees:

When an assisting will be present, it is necessary that the primary surgeon so advise the patient and give the necessary details such as identity and fee to be charged. Please remember: the patient must agree to the presence of the assisting surgeon and the fee to be charged by the assisting surgeon.

Some surgeons have pointed out it is not always possible to provide specific detail before surgery. In those instances we expect the primary surgeon to generally inform the patient of the range of his fee, that an assisting will be present and will bill separately, and that assisting fees generally fall within a "reasonable" percentage of the primary surgeon's fee. If the surgeon does not have any idea of the relativity of the assisting's fees, he should just advise that the doctor will bill separately.

If, however, the assisting is required by law, i.e. Regulation of the State Board of Medical Examiners (13:35-4.1), rather than medical necessity that fact should be made clear to the patient.

7. **FTC Fee Issues.** The issue of binding fee adjudication by judicial committees has not yet been ruled on by the Federal Trade Commission. They have advised MSNJ that they do wish us to continue receiving and deciding fee cases in the interim regardless of their final decision.

8. **Judicial Mechanism Advertisement.** An ad for publication explaining the judicial mechanism is being developed by the Council on Public Relations at the request of the Judicial Council.

The Reference Committee recommends that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

AMA Delegation

KARL T. FRANZONI, MD, CHAIRMAN

(Reference Committee "A")

The American Medical Association has experienced a busy and productive year in fostering the interests of physicians.

ISSUES ADDRESSED BY AMA HOUSE

AIDS. Numerous activities addressed to the management of this major health scourge. All physicians are compelled to enhance their personal knowledge of this disease entity. Education is the current key to prevention of spread.

Professional Liability. Attempts to seek new pathways for resolution, including alternatives to the current tort system. The latter is bound to meet major resistance from plaintiffs, bar, civil liberties groups, and others.

Medicare Reimbursement. Continued negotiations to seek more equitable reimbursement for provided services. Seek withdrawal of participating, nonparticipating distinctions.

Nursing Shortage. A problem of national scope, impacting adversely on the quality of care. Leadership of medicine, nursing, hospitals, and fiscal providers must direct enhanced efforts to accomplish solutions.

Adolescent Health. Major and important educational thrust to be applied by all. Includes teen problems of suicide, pregnancy, and substance abuse.

Foreign Medical Graduates. AMA Board recommended creation of FMG section. House rejected this proposal. Interest is to have all FMGs mainstream their activities into already existent and available channels.

Relative Value Scale. Harvard study due for reporting this year. Considerable input from specialty societies. Will deal with issue of cognitive versus procedural reimbursement. Disagreement and controversy likely.

Smokeless Society. Continued efforts to accomplish this desirable goal by the year 2000.

Budget and Dues. Operating revenues of \$165,870,000, and operating expenses of \$163,090,000. No dues increase for 1988.

Membership has been expanding, but I heartily encourage your participation in a one-on-one campaign to solicit membership in the AMA by your fellow physicians. Regardless of the expressed basis of their disinterest, we require their involvement. Remember, the larger the body, the stronger the voice.

The 20 members of the Medical Society of New Jersey AMA Delegation stand ready, prepared, and able to champion the issues and causes espoused by MSNJ members. They solicit your communications.

We must enlarge and broaden the constituency responsible for decision making concerning health care matters. Physician groupings of themselves cannot create the numerical clout to invoke meaningful change. Public opinion as to the overall quality and rightness of our proposed solutions is essential. This goal requires active involvement, support, and sponsorship by all physicians on a continuing basis.

RESOLUTIONS INTRODUCED BY NEW JERSEY AMA DELEGATION

The following deals with resolutions which were introduced by the Medical Society of New Jersey into the AMA House of Delegates.

1. **Formation of a Section on Foreign Medical Graduates.** The AMA House of Delegates did not approve the establishment of a new Section for Foreign Medical Graduates.

Calling it an emotional and difficult issue, the Reference Committee cited a number of reasons why the new section would result in unmet needs and unfilled expectations among many FMGs:

- Mainstreaming of FMGs in organized medicine is already occurring, and will continue to occur for those who desire to be mainstreamed.

• Concern exists that a section may increase rather than diminish conflicts likely to arise from divergent points of view and the special interests represented by such a heterogeneous group.

• Convincing evidence is lacking regarding the likelihood that membership growth would result from the establishment of a section.

• Most of the issues of interest to FMGs are concerns shared by all physicians and are, therefore, appropriately addressed in a broader forum such as the House of Delegates.

The AMA House concurred with the Reference Committee's belief that FMGs should be encouraged to become actively involved within their local and state societies. (The final vote was 215 against the formation of a section and 145 in favor of its formation.)

2. Equality of Testing Foreign Medical Graduates. This Resolution asked that the AMA (a) urge the National Board of Medical Examiners (NBME) and the Educational Commission for Foreign Medical Graduates (ECFMG) to reach an agreement that graduates of foreign medical schools seeking an accredited residency may take NBME examinations to meet the examination requirement for ECFMG certification, and (b) that the AMA urge the NBME to admit graduates of foreign medical schools to its certification procedures as a means of meeting the examination requirements for licensure.

The Reference Committee heard extensive testimony for, and against, both resolves of the Resolution. Testimony indicated that the examination now used by the Educational Commission for Foreign Medical Graduates is equivalent to the Part I and Part II examinations of the National Board of Medical Examiners. The ECFMG examination is one requirement for the certificate of the ECFMG, which is required if graduates of foreign medical schools are to enter an accredited residency. The NBME, an independent organization, has limited admission to its Part I and Part II examinations to students in or graduates of medical schools accredited by the Liaison Committee on Medical Education (LCME).

The certification procedures of the NBME include not only the passing of its examinations but graduation from a medical school accredited by the LCME and the satisfactory completion of a residency accredited by the Accreditation Council for Graduate Medical Education. The certificate of the NBME may be accepted by a licensing authority in fulfillment of its examination requirement.

The Reference Committee was advised that LCME accredited schools are required to evaluate the ability of their students against known standards. Until an effective system to evaluate foreign medical schools can be implemented, the attributes of such schools are unknown and current procedures for the evaluation of graduates of foreign medical schools appear to be reasonable. The Resolution therefore was not adopted.

3. Hospitals Limited to Participating Physicians. This Resolution from New Jersey asked the AMA to urge Congress to rescind the incentive in the 1986 Budget Reconciliation Act regarding hospital referral of Medicare patients to "participating" physicians.

The AMA House adopted the following Substitute Resolution:

Resolved, that the American Medical Association advise its members that the decision of whether or not to be a "participating" physician in Medicare is a personal choice; and be it further

Resolved, that the AMA use all appropriate means to rescind those recently enacted regulations and statutes which unfairly discriminate against health care providers, and jeopardize the quality, availability, and affordability of health care for the aged and the infirm; and be it further

Resolved, that the AMA request Congress to return to the original intent of the Medicare Law (Title XVIII) as expressed in Sections 1801 and 1802 enacted in 1965; and be it further

Resolved, that the AMA specifically request Congress to rescind the "incentive" in the Omnibus Budget Reconciliation Act of 1986 regarding hospital referral of Medicare patients to participating physicians; and be it further

Resolved, that the AMA work to amend the Medicare law to eliminate any financial incentives to Medicare carriers for signing up large numbers of physician providers; and be it further

Resolved, that the AMA specifically seek to rescind, before its effective date of October 1, 1987, the Omnibus Budget Reconciliation Act of 1986 provision that requires a non-participating physician who performs an elective surgical procedure on an unassigned basis for a Medicare beneficiary to provide the beneficiary in writing the estimated approved

charge under Medicare, the excess of the physician's actual charge over the approved amount and the coinsurance applicable to the procedure.

4. **Forced Assignment on Laboratory Fees.** This Resolution calls on the AMA to oppose forced acceptance of Medicare assignment for diagnostic laboratory tests performed in physicians' offices, and calls the AMA to request repeal of this provision. The Resolution was adopted.

5. **Medicare Nonparticipation.** This Resolution called upon the AMA to advise its members that the Medicare "participation" decision is a personal choice, and to seek to rescind laws and regulations that discriminate against health care providers and jeopardize the quality, availability, and affordability of care for Medicare beneficiaries. The Reference Committee considered this Resolution with New Jersey's Resolution on Hospitals Limited to Participating Physicians. As previously noted, a Substitute Resolution was adopted.

6. **Physician Responsibility in Teaching Programs.** In this Resolution, the AMA was called upon to urge HCFA to alter its position on physician accountability in teaching programs so that residents and fellows are accountable for their own errors, and attendings are accountable only when they have failed to discharge their responsibility.

In December 1987, the AMA Council on Medical Education recommended against seeking a change in the Health Care Financing Administration policy to make residents and fellows accountable for their own areas and attending physicians accountable only when they have failed to discharge their responsibilities. The House of Delegates supported the Council's position.

MSNJ has taken the position that both the Council on Medical Education and the AMA Reference Committee have ignored the impossibility of this situation. HCFA has very clearly instructed the PRO that there is no discretion in teaching programs. Attendings are responsible for every error by students and residents, regardless of when or how the mistake occurred. Current HCFA policy requires PRO to proceed against the attending through several stages, including focused review. Time, resources, and expenses are wasted. Emotional trauma is inflicted on the attending, even though he/she is exonerated at a final PRO hearing.

Following the AMA Interim Meeting, David I. Kingsley, MD, President of The Peer Review Organization of New Jersey, and Robert J. Weierman, MD, Chairman of MSNJ's Committee on Utilization Review Systems, directed a joint communication to James H. Sammons, MD, Executive Vice-President of the AMA, asking for reconsideration. Doctor Sammons replied:

While I appreciate the risk to attending physicians from actions of physicians in training, residents or fellows, Report B of the Council on Medical Education is an affirmation of long-standing AMA policy. Resolution 36 clearly stated its intent to reduce the responsibility of an attending physician to his own actions, and the House of Delegates rejected that concept. There was no confusion; the issue was sharply defined. In the absence of a subsequent action to modify the position, I see no maneuvering room; the attending physician is the one physician responsible for the care of his or her patient in the hospital.

7. **Medicare Reimbursement—Maximum Allowable Actual Charges.** The Resolution calls on the AMA to seek legislative and regulatory changes that will correct the inequities in Medicare maximum allowable actual charges (MAACs) for nonparticipating physicians.

The AMA House of Delegates adopted the following Substitute Resolution:

Resolved, that the AMA continue to seek judicial, legislative, and regulatory changes that will eliminate the Medicare maximum allowable actual charge (MAAC) regulations for nonparticipating physicians; and be it further

Resolved, that, in the meantime, the AMA seek to assure that all Medicare fiscal intermediaries send to nonparticipating physicians adequate information for calculating MAAC levels; and be it further

Resolved, that the AMA support any individual component society's legal efforts to prevent passage or overturn any state law that restricts the right of physicians to contract for services rendered to their patients provided that:

a. The state association applies to the AMA; b. The Board of Trustees agrees that the litigation is meritorious; c. The Board will determine the extent of the support; and d. If the Board of Trustees determines that the request is without merit, it will inform that state association of the deficiencies of its approach.

The Reference Committee recommends that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

Executive Director

VINCENT A. MARESSA

(Reference Committee "A")

The problems and difficulties facing the profession in New Jersey have magnified in the past year. While it is easy enough to distribute blame on a fair number of outside entities that engage in doctor bashing, it is futile to engage in activity that does not meaningfully address the issues. In effect, I am repeating the statement I made last year: we cannot continue the endless debate and internal bickering that is standard operating procedure for organized medicine.

Problems must be identified, strategies developed, and tactics executed to the best of our organizational ability. In order to produce such a system, we all will have to allow a certain amount of ego suppression. No course or response selected can satisfy everyone. That would be utopian—and, by definition, it does not exist. The task is not easy but it is by no means impossible.

The SCI report on impaired and incompetent physicians was inaccurate, unfair, and malicious, and could be equated to bureaucratic terrorism. The real issue is not the report nor the adverse publicity generated by it but what revisions will come about in our licensing laws. The Board has retained Judge Herbert Stern to assist in assuring that the outcome is effective, responsible, and rational. We, therefore, are focusing on the legislative challenge and putting aside the urge to lash out and get even.

The insurance commissioner has announced that practicing physicians who carry malpractice insurance will be surcharged 4 percent of their premium over the next seven years to make up the \$60 million deficit caused by the Department's misfeasance and malfeasance in operating the Malpractice Reinsurance Association. His plan is not final at this point. His plan is fatally flawed and ignores some basic facts. The Association was activated in order to compete with Medical Inter-Insurance Exchange of New Jersey (MIENJ). It was not activated because of an availability crisis. Its rates were set at a rate lower than MIENJ and it had no policyholder reserve. Its failure was a given.

It is inherently wrong, however, to charge its losses to persons never insured by it. It is inherently wrong to say that those insured by it should pay the same surcharge as those not insured by it. It is unfair and even stupid to say that those insured by it but no longer insured in New Jersey should have no obligation whatsoever. If the commissioner follows the course he has tentatively announced, MSNJ and MIENJ are committed to litigate against this unlawful and unfair plan. It is evident that state government can commit a version of malpractice. It is unfortunate that the governor and the Legislature are not more sensitive to that fact. The time is at hand when knowledgeable commissioners must make decisions that are sound and equitable rather than politically expedient.

The problems recited above are political, as are the solutions. We do need 1,000 to 2,000 doctors willing to call and write legislators and government executives. We need 6,000 members to contribute \$20 annually to political action committees. It is your profession and livelihood. You should be committed to its preservation and enhancement. You and you alone will determine the future of your profession, its form and substance. You will do this by the combined effects of your action and inaction.

The Reference Committee recommends that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

Committee on Long-Range Planning and Development

BERNARD ROBINS, MD, CHAIRMAN

(Reference Committee "A")

The Committee met three times this year and, in response to the charge to look to the future for means to improve the structure and operation of the Society, considered:

1. **Nominating Committee Interview Format.** The procedure of conducting personal interviews of each prospective nominee for the positions of officers, trustees, judicial councilors, and AMA delegates and alternates introduced by the Committee on Long-Range Planning and Development was initiated during the 1986-1987 administrative year, and it was encouraging to learn that the procedure proved beneficial to the Nominating Committee.

The Board of Trustees, however, questioned the equitability of the new format and we were asked to look into videotaping the interviews. We did not feel inequities resulted because of the interview format; and did not believe the concept of videotaping was appropriate or useful. A recommendation that candidates be given the option to submit a written statement prior to the time of their interview, setting forth why they believe they are qualified to represent the physicians of New Jersey in the office they are seeking, and also to enclose their recent photograph was approved by the Board. Candidates to be interviewed by the 1988-1989 Nominating Committee will be advised of this option.

2. **Emeritus and Dues-Exempt Members.** The high ratio of emeritus and dues-exempt members was considered an appropriate issue to be studied. Currently, there are 1,800+ members who do not pay dues. Therefore, their Society financial obligations are incumbent upon the 7,700 dues-paying members. Data indicates that of the 880 members over age 70, 380 still are actively practicing; and of the 1,000 physicians in the emeritus category, about 310 still are practicing. We focused our attention on the question of whether the Society can carry an estimated 700 dues-exempt members who currently are working, and at what level should it be considered appropriate to pay dues. The increasing number of claims of financial hardship for reasons other than illness or disability was noted, and we agreed that the Society's policy to require documentation of economic need before members are placed in the dues-exempt category should be maintained. While the Bylaws provide that members who have attained the age of 70 years do not pay dues, it was our feeling that age 70 is not realistic today. The Committee, recognizing the natural tendency to be less productive at that age, has recommended to the Board that a dues reduction schedule be established for physicians over 70 who still are working. We also are recommending that retired physicians and/or out-of-state physicians, who are not members of the Society but wish to subscribe to certain services (*NEW JERSEY MEDICINE*, etc.), pay a fee-for-service for these services only.

3. **Informational Meetings of the General Membership.** The Committee spent much time studying possible ways to achieve a direct line of communication with the general membership of the Society and the officers and Board of Trustees that would be productive and accommodate the needs of the membership. We concluded that an expedient way to accomplish this would be to invite members of county medical societies to a specific meeting of the Board, at which they could participate in an open forum discussion of issues. The county forum would be placed as an item on the Board agenda. The concept has been recommended to the Board of Trustees.

4. **Educational Programs at Annual Meeting.** The question of what educational programs could be offered to promote physician interest and increase attendance at future Annual Meetings was studied. We were unanimous in believing the Society must maintain its educational role and that the Annual Meeting should be a platform for continuing medical education.

The Committee believes that the scientific session format should be re-established at the Annual Meeting. We have recommended that this concept be pursued, and that special emphasis be placed on the blending of major socioeconomic issues and scientific programs.

The Reference Committee recommends that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

Committee on Long-Range Planning and Development

BERNARD ROBINS, MD, CHAIRMAN

(Reference Committee "A")

1. Emeritus and Dues-Exempt Members. An increasing number of members at or below the age of 65 are going into the emeritus category. The number of claims of financial hardship for reasons other than illness or disability also has been increasing. Currently, there are 1,800+ members who do not pay dues. Therefore, their Society financial obligations are incumbent upon 7,700 dues-paying members. The situation was discussed considerably by the Committee on Long-Range Planning and Development.

A study revealed that a significant number of dues-exempt members currently are working. It also showed that a substantial number of members over the age of 70 still are actively practicing. The Committee's recommendation, that the Society's policy to require documentation of economic need before members are placed in the dues-exempt category be continued, was approved by the Board of Trustees.

The Committee recommended that the following dues structure be implemented after age 70, and that eligible members be required to submit a formal request to participate in the dues reduction plan: age 71—member pays full dues; age 72—member pays 75 percent of dues; age 73—member pays 50 percent of dues; age 74—member pays 25 percent of dues; and age 75—dues-exempt/emergitus status.

The Board of Trustees approved the recommendation, which will be referred to the Committee on Revision of Constitution and Bylaws for development of a Bylaw amendment for approval of the 1989 House of Delegates. That Committee will determine whether to recommend the format we have developed or some other version.

A recommendation by the Committee, that emeritus physicians and/or out-of-state physicians, who are not members of the Society but wish to subscribe to certain services (*NEW JERSEY MEDICINE*, etc.) pay a fee-for-service for these services only, also was approved by the Board.

2. Informational Meetings for the General Membership. The development of a format for holding informational meetings for the purpose of disseminating information and giving the general membership the opportunity for feedback was studied by the Committee on Long-Range Planning and Development.

After considerable discussion of methods to achieve a direct line of communication with the general membership and the officers and Board of Trustees that would be productive and accommodate the needs of the membership, the Committee on Long-Range Planning and Development recommended that the president of the Society send letters to the county medical societies, inviting the general membership to attend a specific meeting of the Board of Trustees, to participate in an open forum discussion of issues. (This was not intended to restrict the open invitation to county and specialty societies that already exists.) The Board approved the recommendation. The new procedure will be implemented during the 1988-1989 administrative year.

3. Educational Program at the Annual Meeting. The advantages of holding a number of scientific sessions for CME credits, as formerly conducted at the Annual Meeting, were noted. It was recognized, however, that this format is not possible at the present time due to insufficient space at the hotels accommodating the Annual Meeting. The Committee was made aware that there is the possibility that facilities may be available in the future to accommodate three or four scientific sessions.

The Committee agreed the ultimate future goal of the Society should be the re-establishment of educational programs at the Annual Meeting.

The Board approved the recommendation of the Committee that the Medical Society of New Jersey proceed with the concept of holding scientific sessions at future Annual Meetings, recognizing that the sessions initially may have to be phased in, depending on the availability of required facilities, and that special emphasis be placed on the blending of major socioeconomic issues and scientific programs.

4. Review of MSNJ's Councils and Committees. In reviewing the Society's administrative councils, and standing and special committees, the Committee on Long-Range Planning and Development made the following recommendations:

a. *Advisory Committee to the Auxiliary.* The function of the Advisory Committee is being accomplished through the Auxiliary's liaison with the Board of Trustees. Also, the Bylaws provide for a member of the Auxiliary to be appointed by the president to serve on the Society's councils and committees, and this was observed as another means for promoting dialogue between the Society and the Auxiliary. It also was learned that the Auxiliary was in favor of discontinuing the Committee. The recommendation that the Advisory Committee to the Auxiliary be discontinued was approved by the Board of Trustees. (The action of the Board will be referred to the Committee on Revision of Constitution and Bylaws.)

b. *Committee on Medical Student Loan Fund.* Since most work on the medical student loan fund is performed by the chairman, the Committee on Long-Range Planning and Development questioned the need for appointing other than a chairman and a vice-chairman to serve on this Committee. The recommendation that the Committee on Medical Student Loan Fund consist of only two appointed members (a chairman and vice-chairman) rather than five appointed members, as stipulated in the Bylaws, was not adopted. The Board of Trustees was not in favor of giving two individuals the authority for administering the fund.

c. *Committee on Revision of Constitution and Bylaws; Committee on Long-Range Planning and Development.* The possibility of merging the standing Committee on Revision of Constitution and Bylaws and the Committee on Long-Range Planning and Development was considered. It was the conclusion of the Committee on Long-Range Planning and Development that the coalescence of the two committees would not be in the best interest of the Society. The Board agreed with the Committee's conclusion.

d. *Committee on Child Health.* The Board of Trustees approved the recommendations of the Committee on Long-Range Planning and Development that the Special Committee on Child Health be discontinued, and that the activities of the Special Committee on Maternal and Child Care be expanded to include the Special Committee on Child Health.

e. *Committee on Occupational Health, Workers' Compensation, and Rehabilitation.* The Committee on Long-Range Planning and Development recommended that the Special Committee on Occupational Health, Workers' Compensation, and Rehabilitation be discontinued; and that the activities of the Special Committee be assumed by the Council on Medical Services. The recommendations were approved by the Board of Trustees.

f. *Ad Hoc Committee on Health Care Reimbursement Policies.* Since the Ad Hoc Committee on Health Care Reimbursement Policies continues to be involved in current issues, the Committee on Long-Range Planning and Development recommended that it be changed to a special committee of the Society, to perform as originally charged. Also, that members of the Committee be appointed by the president, and include representatives from the major specialty societies. The recommendations were not adopted by the Board of Trustees. The Ad Hoc Committee on Health Care Reimbursement Policies will be disbanded and the Council on Medical Services will assume responsibility for its activities. (Doctor Formica, president-elect, indicated that she will review the membership of the Ad Hoc Committee and select individuals from that Committee to serve on the Council on Medical Services.)

5. Speaker and Vice-Speaker of the House of Delegates.

a. *Speaker and Vice-Speaker Positions.* In accordance with Chapter II, Section (b) of the Bylaws, the president appoints the speaker and vice-speaker of the House of Delegates. The concept of changing these from presidential appointments to elected positions was discussed by the Committee.

The following recommendations will be considered at the next regular meeting of the Board of Trustees, following the Annual Meeting, when the speaker of the House of Delegates can be present to address the concept:

(1) That the speaker and vice-speaker be elected by the House of Delegates through the Society's Nominating Committee process.

(2) That the term of office for the speaker and vice-speaker be for two years, and that they be limited to three such terms.

b. *Ex Officio Seat on Board of Trustees.* The recommendation of the Committee on Long-Range Planning and Development that the speaker of the House of Delegates be given a non-voting, ex officio seat on the Board of Trustees will be considered at the next meeting of the Board, following the Annual Meeting, when the speaker can be present to address the issue.

6. Leadership Seminar. The concept of offering educational seminars to provide a training program for potential leaders of the Society was introduced and will be discussed further at future meetings of the Committee on Long-Range Planning and Development.

The Reference Committee recommends that the supplemental report be filed.

HOUSE ACTION: Adopted. The supplemental report was filed.

Committee on Physicians' Health

RONALD I. FORSTER, MD, CHAIRMAN

(Reference Committee "A")

The following report details some of the activities for the past year:

1. **Program Name Change.** The Committee recommended and MSNJ's Board of Trustees approved renaming the program the Physicians' Health Program. The Committee will be renamed the Committee on Physicians' Health. This fits with similar program names in other states. Such a name change was endorsed at the AMA meeting in Chicago in October. It will resolve some of the misconceptions about the competence of program clients.

2. **The SCI Report.** The State Commission on Investigation (SCI) released a report on impaired and incompetent physicians that was highly critical of the MSNJ program, the malpractice insurance carriers, and the State Board of Medical Examiners. While there were some reasonable positive recommendations, we felt that the report was essentially biased (reviewed from the point of view of a prosecuting attorney addressing a criminal population) and unfair (it relied on half-truths and incomplete data in some of its conclusions). The net effect has been positive. It has rallied the support of the Society around the program and may well open the door to a major improvement in the current disciplinary system.

3. **AMA 8th National Conference on the Impaired Physician.** MSNJ and our program were well represented at this national meeting. Dr. Canavan and Rev. Reading were both faculty members at this conference.

4. **Physician Health Program Grant Fund/Treatment Loan Fund.** To comply with state law regarding distribution of monies received as a result of a raffle, the Treatment Loan Fund has been divided into two separate funds: The Treatment Loan Fund, developed from donations made by pharmaceutical companies and from a number of individuals, will provide low-interest loans to physicians and/or their families while the physician is in treatment and/or suspended from practice. The Grant Fund was developed for the distribution of monies received from the annual raffle. State law prohibits the lending of raffle proceeds. Monies must be granted.

5. **Annual Raffle.** The 1987 raffle proceeds increased the Grant Fund total with an additional \$34,082.59. The program's three raffles have netted \$47,057.59. Since last year's raffle, \$13,650.00 in grants have been distributed.

6. **Joint Conference with the State Board of Medical Examiners.** To date, we have been unable to reach a mutually convenient date for a joint meeting with the State Board of Medical Examiners Committee on Long-Range Planning and Development. Program staff will continue its efforts to arrange this conference.

7. **Adopt-a-Family Program.** Because of the success of the 1986 "Adopt-a-Family for the Holidays Program," the Physicians' Health Program again solicited the help of MSNJ's Board of Trustees, County Medical Societies, County Auxiliaries, and NJAOPS and its Auxiliary for this year's fund. A total of \$4,541 was collected. Cash gifts were distributed to seven physicians and their families. These included both MDs and DOs. Five children received Christmas and Hanukkah gifts at holiday time.

8. **AIDS.** The Committee recognized that the problem of AIDS within the medical community will become a significant reality in the foreseeable future and will have to be addressed. The Committee recommended that the Board of Trustees establish a task force representative of the various medical entities of the profession for the purpose of developing clear-cut policies and protocols for physicians diagnosed as having AIDS or found to have a positive HIV titer. It was agreed that the program would not accept the addition of AIDS-afflicted physicians as an additional "impaired" group. However, physicians already involved in the program as a result of drug or chemical dependency who subsequently develop a positive HIV titer will be eligible for extended assistance from the program.

9. **Drug Abuse Insurance for Society Members.** The Committee submitted a recommendation to the Board of Trustees requesting that a study be undertaken of the health insurance policies endorsed by MSNJ. The purpose of this study would be to evaluate the practicality of adding coverage for drug abuse. The Committee noted that it would be a contradiction for

organized medicine to support drug abuse as an illness and to deny its own members coverage because of inappropriately endorsed insurance.

10. **Statistical Summary.** A statistical illustration of our program's activities from September 7, 1982, through December 31, 1987 follows:

	<i>Number</i>	<i>Percentage</i>
<i>Total Cases</i>	403	100.0
MD	341	84.6
DO	33	8.2
DVM	8	2.0
Student	5	1.2
Other	16	4.0
Male	363	90.1
Female	40	9.9
<i>Primary Impairment</i>		
Alcohol	147	36.5
Drugs	128	31.8
Psychiatric	89	22.1
Senility	11	2.7
Other	28	6.9
<i>Referral Source</i>		
Colleague	200	49.6
Self	74	18.4
Family	42	10.4
State Board of		
Medical Examiners	22	5.4
County Medical Society	18	4.5
Treatment Center	19	4.7
Other	28	7.0

The Reference Committee recommends that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

Board of Trustees' Item

RESOLUTION #2 AND SUBSTITUTE RESOLUTION #2 (1987): X-RAY DEMONSTRATION OF CHIROPRACTIC SUBLUXATION

(Reference Committee "A")

These Resolutions deal with whether or not medical x-rays document the existence of chiropractic subluxation. Following the close of the 1987 Annual Meeting, the Board referred them to legal counsel for study.

In his report, legal counsel points out that the difficulty confronted is that chiropractic subluxation is not a medically recognized disease process or anatomical condition. The American College of Radiology maintains that radiologists interpret x-rays from a medical perspective and do not make chiropractic findings.

X-ray confirmation of subluxation was not an issue in the *Wilk* case which involved the AMA. The AMA reports that one study has been performed showing no intraobserver correlation in the interpretation of x-ray films by chiropractors and radiologists.

The difficulty presented by both Resolutions is the assumption that chiropractic subluxation is to be evaluated in terms of a medical diagnostic technique, while the law and the practitioners of chiropractic maintain it is totally different from concepts in medicine. Both Resolutions are inappropriate in attempting to correlate chiropractic into "medical care" and then to indicate that subluxation is not medically demonstrable. Chiropractic simply is not medical care.

In view of the above and the potential for litigation, legal counsel sees no practical benefit to adoption of either of the Resolutions. The state Legislature and Congress already know that chiropractic is not medical and is not based on medically recognized concepts.

The Board of Trustees supported legal counsel's opinion.

After considerable discussion, the Reference Committee suggested that physicians should concentrate on practicing optimal medical care and educating patients about the diagnostic and therapeutic limitations of limited licensed practitioners.

The Reference Committee recommends that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

Resolution #3

Introduced by: Essex County Medical Society
Subject: Critical Bedside Nurse Shortage
Referred to: Reference Committee "A"

Whereas, there is an increasingly critical shortage of bedside nurses in both New Jersey hospitals and nursing homes; and

Whereas, there is a decreasing number of student nurses and a diminishing source of nursing education in the state of New Jersey; and

Whereas, adequate patient care requires a continuing supply of nurses; and

Whereas, any further reduction in bedside nurses will result in substandard patient care; now therefore be it

Resolved, that the Medical Society of New Jersey attempt to achieve the following:

- a) Seek private and public means of encouraging programs to produce more bedside nurses.
 - b) Solicit the Department of Higher Education to enlarge existing programs and to generate new programs, including three-year nursing schools.
 - c) Seek legislation to address this nursing shortage crisis.
 - d) Attempt to establish scholarships and student loan programs to encourage more nursing applicants.
 - e) Encourage career guidance counselors to promote awareness of opportunities in nursing.
- The Reference Committee considered Resolutions #3 and #20 jointly because of the similarity of the subject matter.

The Reference Committee recommends that Resolution #3 be rejected.

HOUSE ACTION: Adopted. Resolution #3 was rejected.

Resolution #4

Introduced by: Ocean County Medical Society
Subject: Inducting Osteopathic Physicians in County Medical Societies
Referred to: Reference Committee "A"

Whereas, it is deemed important to increase the number of physicians participating in medical activities at a county medical society level; and

Whereas, it is deemed important to increase county medical society membership by inducting osteopathic physicians into the county medical societies; and

Whereas, it currently is the rule that osteopathic physicians must join the Medical Society of New Jersey in order to qualify for a county medical society membership; and

Whereas, many osteopathic physicians are members of the New Jersey Association of Osteopathic Physicians and Surgeons and would join a county medical society but for the constraint of double dues; and now therefore be it

Resolved, that the osteopathic physicians who are active members of the New Jersey Association of Osteopathic Physicians and Surgeons be permitted to join a county medical society freed from the stipulation of first joining the Medical Society of New Jersey.

Osteopathic physicians currently are eligible for membership as regular members with the same rights and responsibilities as M.D.s under the existing bylaws, and the Reference Committee does not believe this policy should be changed.

The Reference Committee recommends that Resolution #4 be rejected.

HOUSE ACTION: Adopted. Resolution #4 was rejected.

Resolution #18

Introduced by: Bergen County Medical Society
Subject: Specialty Society Judicial Committee Review
Referred to: Reference Committee "A"

Whereas, judicial committees of county medical societies perform an invaluable function in handling complaints against member physicians; and

Whereas, these judicial committees often are requested to pass judgment on the quality of patient care which involves functions of such nature that only a specialist would be able to render judgment; and

Whereas, these county judicial committees would benefit from receiving consultations from experts in specialty fields; now therefore be it

~~Resolved, that the Medical Society of New Jersey Judicial Council request specialty societies in New Jersey to be ready to act as advisory panels for county judicial committees in cases involving quality of patient care; and be it further~~

~~Resolved, that the specialty society review functions be performed as quickly as possible and that the opinion be returned promptly to the inquiring judicial committee of the county society for final determination.~~

Resolved, that the Medical Society of New Jersey Judicial Council request specialty societies to provide expert reviewers to act in an advisory capacity to county judicial committees in cases involving quality of patient care.

The Reference Committee recommends that Resolution #18 be amended (italics indicate amendments).

HOUSE ACTION: Adopted. Resolution #18 was adopted as amended by the Reference Committee.

Resolution # 20

Introduced by: Bergen County Medical Society
Subject: Solving the Nursing Shortage
Referred to: Reference Committee "A"

Whereas, it is estimated there will be a need for 1.2 million nurses by the year 2000; and

Whereas, there is an increasing shortage of available nurses to staff our hospitals; and

Whereas, this shortage problem has been compounded by two factors: enrollment in nursing schools has dropped 20 percent, and four major nursing schools have closed; and

Whereas, the shortage can be noted by individual practitioners in the hospitals with regard to care of their patients and available operating room time for surgeons; and

Whereas, there appears to be no unified action by the state and county governments to address the nursing shortage; now therefore be it

~~Resolved, that the Medical Society of New Jersey, through the development of a new committee or a standing committee, combine its efforts with a similar committee from the New Jersey State Nurses Association; and be it further~~

~~Resolved, that this committee should actively and aggressively confront the shortage of nurses, and define the issues and reasons; and be it further~~

~~Resolved, that this problem be presented to members of state and county governments and the New Jersey Department of Health with the urgent request that aggressive action be implemented to increase the number of professional nurses and with the added goal of making nursing a desirable profession.~~

The Reference Committee considered Resolutions #3 and #20 jointly because of the similarity of the subject matter.

The Reference Committee recommends that the following Substitute Resolution for Resolution #20 be adopted:

Whereas, it is estimated there will be a need for 1.2 million nurses and technicians by the year 2000; and

Whereas, there is an increasing shortage of available nurses and technicians to staff our hospitals; and

Whereas, this problem has been compounded by two factors: enrollment in nursing schools has dropped significantly, and four major nursing schools have closed; and

Whereas, the situation has been noted by individual practitioners in the hospitals with regard to care of their patients and available operating-room time for surgeons; and

Whereas, there appears to be no unified action by the state and county governments to address the shortage of nurses and technicians; now therefore be it

Resolved, that the Medical Society of New Jersey, through the development of a new committee or standing committee, combine its efforts with similar committees from other associations *to address the shortage of nurses and technical personnel*; and be it further

Resolved, that this committee, *which will address the shortage of nurses and technical personnel*, should actively and aggressively confront the shortage of nurses and technicians and define the issues and reasons, such as:

(a) Adequate remuneration for their services; and

(b) Soliciting the New Jersey Department of Higher Education to enlarge existing programs and to promote accelerated educational programs in nursing and technical services; and

(c) Encourage career guidance counselors to promote awareness of opportunities in nursing and technical fields; and be it further

Resolved, that the problem of *the shortage of nurses and technical personnel* be presented to members of state and county governments and the New Jersey Department of Health with the urgent request that aggressive action be implemented to make technical and nursing careers desirable, and to increase the number of professional nurses and technicians.

HOUSE ACTION: Adopted. Resolution # 20 was adopted as amended by the Reference Committee with editorial changes (noted in italics) by the House.

Resolution #22E

Introduced by: Bergen County Medical Society
Subject: Senior Medical Courtesy Programs
Referred to: Reference Committee "A"

Whereas, the majority of county medical societies in New Jersey now have enacted, or are considering enacting, a program of financial medical assistance for the qualifying needy senior citizens; and

Whereas, immediate unified action by the physicians of the state of New Jersey now is imperative; now therefore be it

Resolved, that the Medical Society of New Jersey immediately encourage all the remaining county medical societies to adopt a similar financial medical assistance program *similar to the senior medical courtesy program*; and be it further

Resolved, that every physician member of the Medical Society of New Jersey be urged to participate in ~~this valuable program~~ *the senior medical courtesy program*; and be it further

Resolved, that every component society encourage dialogue on a frequent and regular basis *with senior citizens*.

This Resolution reemphasizes the Society's concern and regard for the needs of our senior citizens.

The Reference Committee recommends that Resolution #22E be adopted.

HOUSE ACTION: Adopted as amended by the House (amendments in italics).

1988 HOUSE OF DELEGATES

**Medical Society of New Jersey
222nd Annual Meeting
April 28 – May 1, 1988**

REFERENCE COMMITTEE “B”

REPORTS

Secretary

Treasurer

Committee on Finance and Budget

Committee on Annual Meeting

Nominations for Emeritus Membership

MEMBERS

Elmar G. Lutz, MD, Chairman

John S. Garra, MD

C. Clayton Griffin, MD

James F. Marley, MD

Gerald S. Packman, MD

Raymond S. Buch, MD, Alternate Member

Secretary

BERNARD ROBINS, MD

(Reference Committee "B")

The office of the secretary has continued its usual routines, primarily involving maintenance of membership records, correspondence, minutes of Board of Trustees' meetings, telephone inquiries, and completion of numerous questionnaires originating from various sources.

During the administrative year, the secretary attended the meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

Membership (as of December 31, 1987)

Active:	Paid	7,567	
	Exempt	863	
Resident:	Paid	189	8,619***
*Associate:	Paid		82
**Affiliate:	Paid		102
	Exempt		5
State Emeritus			986
Total			<u>9,794</u>
Provisional Residents (six months)			25
State Honorary			1
New and Reinstated Members:			
Active			496
Resident			105
*Associate			51
**Affiliate			3
Change of status			63
Transfers within the state			47
Transfers out-of-state and resignations			129
Members deceased			123
Members dropped			217
Active:			
a. Nonpayment of dues		144	
b. Did not comply with Bylaw requirements			
regarding continuing medical education		31	
c. New Jersey license suspended		2	
d. New Jersey license retired		1	
e. New Jersey license voluntarily surrendered		1	
Resident (nonpayment of dues)		28	
*Associate (nonpayment of dues)		9	
**Affiliate (nonpayment of dues)		1	
*Associate membership (nonlicensed in New Jersey) designates interns and residents.			
**Affiliate membership physicians who no longer practice in New Jersey.			
***Adjusted for transfers out-of-state, resignations, and deaths.			

A comparison of December 31, 1987, to December 31, 1986, by county shows the following net changes of active paid membership:

Atlantic	+ 2	Gloucester	0	Ocean	+12
Bergen	- 6	Hudson	- 20	Passaic	- 8
Burlington	+ 5	Hunterdon	+ 3	Salem	- 3
Camden	0	Mercer	- 2	Somerset	+ 1
Cape May	- 3	Middlesex	+13	Sussex	+ 2
Cumberland	0	Monmouth	+16	Union	- 3
Essex	- 53	Morris	+19	Warren	- 6

AMA Membership. A total of 9,205 members of the Medical Society of New Jersey maintain active membership in the AMA. The Society's representation in the AMA House of Delegates stands at ten delegates—one for each thousand members, or fraction thereof.

Credentials. The Committee on Credentials throughout the year reviewed and acted upon membership applications and their supporting credentials as submitted through the component societies. The following statistical breakdown reflects the Committee's activities during the period February 15, 1987, through February 14, 1988:

Received:	<u>Provisional Residents</u>		<u>Active</u>	<u>Grand Total</u>
	<u>*Associate</u>	<u>Licensed</u>		
	41	66	458	565
Reviewed and found:	<u>Provisional Residents</u>		<u>Active</u>	<u>Grand Total</u>
	<u>*Associate</u>	<u>Licensed</u>		
(A) Satisfactory	37	59	404	500
(B) Unsatisfactory	0	0	0	0
Pending:	4	6	36	46
Withdrew:	0	1	18	19
Grand Total	<u>41</u>	<u>66</u>	<u>458</u>	<u>565</u>

*Associate membership (nonlicensed in New Jersey) designates interns and residents.

The Committee extends appreciation to the directors and the secretaries of component societies, and to those who assist them, as well as the County Credentials Committees, for their cooperation in processing membership applications. It especially would be helpful to the Credentials Committee of the Medical Society of New Jersey if those who process credentials in the component societies would call specific attention to any deficiencies or questionable data being submitted on the application form. This procedure will help insure more accurate and speedy evaluation of credentials. The chairman wishes to thank his Committee members for their diligence and cooperation.

Membership Directory. The 1987 edition of the Membership Directory has been available for one year. Since the original distribution of 9,613 copies to members, 1,978 copies have been sold to others. It is anticipated that data sheets for the 1989 edition will be mailed to members in early summer 1988. Your cooperation in returning them promptly will be greatly appreciated.

A question was raised concerning a discrepancy between the total membership reflected in this report and the total number of AMA members from the Medical Society of New Jersey in this report. The executive director explained that the figure of 9,205 includes New Jersey physicians who may not necessarily be members of the Medical Society of New Jersey.

The Reference Committee recommends that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

Treasurer

JOSEPH A. MICALÉ, MD

(Reference Committee "B")

These interim financial statements, prepared in accordance with generally accepted accounting principles, reflect the financial position and results of operation of the Medical Society of New Jersey through January 31, 1988.

Since they are interim statements, the figures are unaudited. A complete audit will be conducted of the books of the Society as of May 31, 1988, and an audited report prepared as of that date. A complete audit was made as of May 31, 1987.

Medical Society of New Jersey
Balance Sheet
January 31, 1988
(Unaudited)

Assets

Cash		\$ 38,494
Investment in money market fund		617,614
Marketable securities—(approximate market)		2,294,348
Accounts receivable—member assessments		878,625
Medical Student Loans (net allowance for doubtful loans of \$20,000)		346,400
Property, Plant, and Equipment		
Land	\$ 150,000	
Building and improvements	2,551,229	
Furniture and fixtures	514,564	
	3,215,793	
Less allowance for depreciation	(786,983)	2,428,810
Prepaid expenses		88,287
Other assets		139,740
		<u>\$6,832,318</u>

Liabilities and Fund Balance

Accounts payable and accrued expenses	\$ 313,288
Assessments collected for AMA	29,761
	<u>343,049</u>
Mortgage payable	1,411,733
Deferred revenue from member assessments	2,268,750
Deferred revenue—Public Relations Assessment	543,331
Deferred revenue—other	167,494
Fund Balance	<u>2,097,961</u>
	<u>\$6,832,318</u>

*Medical Society of New Jersey
Statement of Revenue and Expenses
8 Months Ended January 31, 1988
(Unaudited)*

Revenue

Membership Dues	\$1,569,781
Publication sales and advertising income	194,358
Amortization of Impaired Physicians Program	126,101
Amortization of Public Relations Assessment	13,763
Investment income	73,818
Royalty income	116,547
Rental income	95,804
Annual Meeting	29,259
Other income	57,831
Total Revenue	<u>2,277,262</u>

Expenses

Conferences and Meetings	498,194
Member Services	492,014
Total Program Expenses	<u>990,208</u>
General and Administrative	1,061,825
Interest	94,835
Depreciation	74,043
Total Expenses	<u>2,220,911</u>

Excess of Revenue over Expenses	\$ 56,351
Fund Balance at June 1, 1987	<u>2,041,610</u>
Fund Balance at January 31, 1988	<u><u>\$2,097,961</u></u>

The Reference Committee recommends that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

Committee on Finance and Budget

MATIS A. FERMAGLICH, MD, CHAIRMAN

(Reference Committee "B")

The Committee on Finance and Budget met on Thursday, March 31, 1988, for the purpose of reviewing the proposed budget for the 1988-1989 fiscal year.

The proposed budget and the following recommendations were approved by the Board of Trustees on April 10, 1988, and are submitted to the House of Delegates for approval:

Recommendations

1. That the budget for the fiscal year beginning June 1, 1988, and ending May 31, 1989, in the amount of \$3,750,000 with \$2,537,000 to be raised through member assessments be adopted.

2. That the 1989 assessment be set at \$350 per regular dues-paying member. (The 1988 assessment was \$330.)

3. That the 1989 assessment be set at \$60 per member for affiliate members (no longer practicing in New Jersey). (The 1988 assessment was \$40.)

4. That the 1989 assessment for associate members (interns-residents licensed in New Jersey) and licensed residents, provided the individual is in a residency program entered upon within a reasonable time after his or her graduation from medical school, be set at \$25. (No change from prior year.)

5. That the 1989 assessment be set at \$10 per student for medical students. (No change from prior year.)

Medical Society of New Jersey Statement of Revenue and Expenses Proposed Budget Fiscal Year Ending May 31, 1989

Revenue (other than member assessments)

Publication sales and advertising income	\$ 208,000
Amortization of Physicians' Health Program	230,000
Amortization of Public Relations Assessment	200,000
Investment income	60,000
Royalty income	223,000
Rental income	205,000
Annual Meeting	15,000
Membership Directory sales	60,000
Other income	12,000
Total Revenue	\$1,213,000

Expenses

Conferences and meetings	849,000
Member services	555,000
Publications	282,000
Total Program Expenses	1,686,000
General and administrative	1,785,000
Interest	139,000
Depreciation	140,000
Total Expenses	\$3,750,000

Amount of expenses over revenue to be raised
through member assessments (including *NEW JERSEY MEDICINE*
subscriptions and Annual Meeting assessments)

\$2,537,000

Revenue From Member Assessments Fiscal Year Ending May 31, 1989

(7 months) 6/1/88 through 12/31/88 @ \$330 x 7,500 members	\$1,443,750
(5 months) 1/1/89 through 5/31/89 @ \$350 x 7,500 members	1,093,750
	<u>\$2,537,500</u>

Medical Society of New Jersey
Proposed Budget
Fiscal Year Ending May 31, 1989

	Approved Budget 1987/88	Estimate for Y/E 5/31/88	Proposed Budget 1988/89
Compensation			
Salaries	\$ 935,000	\$ 945,500	\$1,002,000
Pension Plan	109,000	76,500	117,000
	<u>1,044,000</u>	<u>1,022,000</u>	<u>1,119,000</u>
Professional Fees			
Audit	18,000	20,000	20,000
Legal	25,000	61,000	45,000
Actuarial	3,000	2,000	3,000
Special Consultants	10,000	14,000	15,000
	<u>56,000</u>	<u>97,000</u>	<u>83,000</u>
Councils and Committees			
Public Relations	250,000	250,000	250,000
Public Relations—Special Assessment	—	150,000	200,000
Legislation	75,000	75,000	80,000
President and Presidential Officers	50,000	59,000	70,000
AMA Delegates	80,000	65,000	85,000
MSNJ Auxiliary	24,000	24,000	25,000
Medical Education	34,000	35,000	35,000
Board of Trustees	35,000	30,000	35,000
Judicial Council	1,000	1,000	1,000
Reimbursement of Reps. to Mtgs.	3,000	3,000	3,000
Other Councils and Committees	25,000	51,000	50,000
Medical Student Association	16,000	14,000	15,000
	<u>593,000</u>	<u>757,000</u>	<u>849,000</u>
Member Services			
Physicians' Health Program	275,000	275,000	335,000
Annual Meeting	115,000	115,000	120,000
Professional Liability	45,000	40,000	45,000
Membership Directory	45,000	43,000	55,000
	<u>480,000</u>	<u>473,000</u>	<u>555,000</u>
Publications			
NEW JERSEY MEDICINE	<u>259,000</u>	<u>278,000</u>	<u>282,000</u>
Donations			
Grant to MSNJ Medical Student Loan Fund	<u>3,000</u>	<u>3,000</u>	<u>—</u>
General Administrative and Operating Expenses			
Building operations—including depreciation	431,200	408,000	437,000
Insurance	147,000	146,000	158,000
Payroll taxes	71,000	70,000	73,000
Other general office cost	175,800	160,000	194,000
	<u>825,000</u>	<u>784,000</u>	<u>862,000</u>
TOTAL	<u>\$3,260,000</u>	<u>\$3,414,000</u>	<u>\$3,750,000</u>

The Reference Committee recommends approval of recommendations 1 through 5.

HOUSE ACTION: Adopted. The recommendations were approved.

The Reference Committee recommends that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

Committee on Annual Meeting

ANGELO S. AGRO, MD, CHAIRMAN

(Reference Committee "B")

The construction of Resorts Taj Mahal Casino Hotel in Atlantic City will not be completed for the Medical Society of New Jersey's 1988 Annual Meeting scheduled for Thursday, April 28 to Sunday, May 1, 1988. Therefore, we were forced to change the site of the 1988 Annual Meeting.

The Committee reviewed proposals on available sites for the Annual Meeting submitted by: Trump Plaza Hotel and Casino/Atlantis Casino Hotel, Atlantic City; Showboat Hotel, Casino & Bowling Center/Sands Hotel, Atlantic City; and Sheraton Meadowlands Hotel, East Rutherford.

The Board of Trustees of the Medical Society of New Jersey at its September 20, 1987, meeting approved the recommendation that the 1988 Annual Meeting be held at the Sheraton Meadowlands Hotel in East Rutherford.

The following sites also have been investigated and rejected based on the present format demanding specific requirements, they do not have adequate space: Berkeley-Carteret/Asbury Park; Flanders Hotel/Ocean City; Hyatt Regency/Princeton; Loews Glenpointe Hotel/Teaneck; The Parsippany Hilton/Parsippany-Troy Hills; and Scanticon/Princeton.

The 1988 House of Delegates will meet on three consecutive days, beginning with its opening session on Thursday afternoon, April 28. The election will be held on Friday, April 29, and the last session of the House will be held on Saturday. Reference committees are scheduled to meet on Thursday and Friday afternoons (April 28 and 29). The Inaugural Reception and Dinner-Dance honoring President-Elect Palma E. Formica, MD, will be held on Saturday, April 30.

The general session, scheduled for 8:30 A.M., Sunday, May 1, will be on the topic of AIDS.

JEMPAC's Political Forum will be at 5:00 P.M. on Friday, April 29, followed by the JEMPAC Wine & Cheese Reception at 5:45 P.M. Senator Frank J. Lautenberg, who is running for reelection this year and the Republican challenger, General "Pete" Dawkins, have been invited as guest speakers.

Permission was granted by the management of the hotel to have 20 (6' x 8') exhibits in the hallway, a prime area on the second floor—the location for all meetings and functions.

The New Jersey Society of Medical Assistants again will sponsor the Message Center.

Housing applications were sent to all component medical societies, and copies have appeared in *NEW JERSEY MEDICINE*, the journal of the Medical Society of New Jersey.

The Advance Convention Program was mailed in March.

The 1987 House of Delegates approved the recommendations that the Committee on Annual Meeting consider the Meadowlands Complex, along with Resorts Taj Mahal Casino Hotel for the 1989 and 1990 Annual Meetings. These recommendations will be evaluated by the Committee. With the approval of the Board of Trustees, a report advising the site and date of the 1989 Annual Meeting will be circulated to all component medical societies, and appear in *NEW JERSEY MEDICINE*.

During a discussion of the reasons for the selection of the Sheraton Meadowlands Hotel for the 1988 Annual Meeting, the chairman of the Committee on Annual Meeting informed the Reference Committee of the reluctance of Atlantic City hotels to accommodate the Medical Society in an acceptable manner. A comparison of attendance figures for the last four years highlights a marked increase for this year: 1985—432; 1986—349; 1987—326; and 1988—464 (as of April 29, 1988).

The Reference Committee recommends that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

Nominations for Emeritus Membership

(Reference Committee "B")

The following nominations for election to emeritus membership at the 1988 Annual Meeting have been received from the component societies. Conforming to the provisions of the Bylaws, Chapter I—Membership, Section 1—Composition (d), all nominees have been members in good standing of a component society and who by reason of age or infirmity have retired from the active practice of medicine, or members of this Society who have been disabled by reason of military service.

Atlantic County

Earl I. Kanter, M.D., Margate; age 67
Max C. Peperik, M.D., Oceanville; age 63
Victor M. Ruby, M.D., Atlantic City; age 68
Sydney H. Starrels, M.D., Ventnor; age 64

Bergen County

Calvin Ackerman, M.D., Teaneck; age 54
Joseph C. Braun, M.D., Fort Lee; age 77
Barnett L. Elkin, M.D., Westwood; age 65
Herbert M. Eskwitt, M.D., Tenaflly; age 64
Rudolph Frank, M.D., Washington Township; age 65
Gerald J. Gordon, M.D., Englewood Cliffs; age 52
Gladys C. Halvorsen, M.D., Tenaflly; age 60
Nancy N. Hsieh, M.D., Fort Lee; age 77
Arthur W. Jacoby, M.D., Bradenton, FL (formerly Westwood); age 62
C. Donald Kuntze, M.D., Cohoes, NY (formerly Fort Lee); age 66
William B. Ober, M.D., Tenaflly; age 68
John P. O'Connor, M.D., Upper Saddle River; age 71
Edward P. Putkowski, M.D., Fort Lee; age 67
Howard J. Rosenbauer, M.D., Hillsdale; age 73
Martin C. Rosner, M.D., Paramus; age 56
Paul H. Schoen, D.O., Englewood; age 60
Richard A. Slezak, M.D., Saddle River; age 66
Gustav G. Steneck, M.D., Tenaflly; age 71

Burlington County

Merla O. Adriano, M.D., Moorestown; age 59
Major Darst, M.D., Vincentown; age 66
Eli B. Halpern, M.D., Moorestown; age 58
John W. Nicholson, III, M.D., Moorestown; age 74
Marco A. Paredes, M.D., Willingboro; age 66
Simone R. Schulmann-Durand, M.D., Moorestown; age 59
Keith R. Young, M.D., Beverly; age 66

Camden County

Georgia E. Allen, M.D., Medford; age 69
Raymond A. Baker, M.D., Voorhees; age 68
Reuben Block, M.D., Haddonfield; age 68
S. Thomas Carter, Jr., M.D., Moorestown; age 61
Jerome R. Dorkin, M.D., Pennsauken; age 67
Norman L. Grant, M.D., Cherry Hill; age 66
G. Vernon Judson, Jr., M.D., Haddonfield; age 75
Frank Kelly, M.D., Gloucester; age 66
John P. McNally, M.D., Voorhees; age 66
John M. Pulliam, Jr., M.D., Collingswood; age 68

Cumberland County

Samuel B. Pole, III, M.D., Bridgeton; age 68

Essex County

Charles P. Abbott, M.D., Belleville; age 52
Angelo D. Calabrese, M.D., Berkeley Heights; age 67
Ogden B. Carter, Jr., M.D., Short Hills; age 68
William C. Conroy, M.D., Roseland; age 71
Anthony R. Fernicola, M.D., Allenhurst; age 71
Hyman W. Fisher, M.D., Livingston; age 62
Mohammad B. Hosseini, M.D., Toms River; age 66
John W. Myers, M.D., Montclair; age 69
Lillian W. Rosenberg, M.D., Montclair; age 71
Sidney M. Rubin, M.D., Short Hills; age 72
Stuart R. Silver, M.D., Sarasota, FL (formerly Glen Ridge); age 61
Rosario Tamburri, M.D., Nutley; age 68
Allison D. Teaze, M.D., Little Falls; age 69
Irene S. Terlecky, M.D., South Orange; age 67
Harry C. Wortman, M.D., Montclair; age 71
Jerome H. Zins, M.D., Millburn; age 61

Gloucester County

Robert B. Hutcheson, M.D., Wilton Manors, FL (formerly Woodbury); age 65

Hudson County

John L. Costello, M.D., Jersey City; age 69
Russell W. Dorn, M.D., Colts Neck; age 73
Arthur D. Hertzberg, M.D., Bayonne; age 67
Raymond E. Pennie, M.D., Mays Landing; age 66
Carl A. Restivo, Sr., M.D., Naples, FL (formerly Jersey City); age 64

Hunterdon County

Raymond E. Fidellow, M.D., Oldwick; age 74

Mercer County

Sol Browdy, M.D., Lawrenceville; age 69
Edmund R. Cytowic, M.D., Altamonte Springs, FL (formerly Forked River); age 66
Martin Epstein, M.D., Yardley, PA (formerly Trenton); age 69
Norman W. Garwood, M.D., Crosswicks; age 76
Leonard Gold, M.D., Yardley, PA (formerly Trenton); age 68
Giuliano Gorelli, M.D., Pennington; age 64
Irfan Kayaalp, M.D., Trenton; age 61
Sydney B. Lewis, M.D., Trenton; age 70
Angelo J. Migliori, M.D., Bay Head; age 69
Jorge Mora, M.D., Trenton; age 67
Peter J. Norton, M.D., Trenton; age 74
Theodore B. Podkul, M.D., Trenton; age 68
Ronald J. Potash, M.D., Lawrenceville; age 58
Bernard Schnur, M.D., Trenton; age 71
Murray D. Shepp, M.D., Morrisville, PA (formerly Trenton); age 67
B. Earl Smith, M.D., Morrisville, PA (formerly Trenton); age 72
Richard W. Ziegler, M.D., Trenton; age 67
Mario L. Zingarini, M.D., Titusville; age 62

Middlesex County

Edward A. Brady, Jr., M.D., New Brunswick; age 70
W. Donald Horrigan, M.D., Isle La Mott, VT (formerly New Brunswick); age 57
William G. Kuhn, Jr., M.D., Bound Brook; age 73
Irving I. Luftman, M.D., Cranbury; age 66
Bernard J. Miller, M.D., Highland Park; age 70
Robert M. Niemiera, M.D., Perth Amboy; age 36
Joseph Uhrik, M.D., Piscataway; age 71

Monmouth County

Richard H. Demaree, M.D., West Long Branch; age 70
Arthur W. Faust, M.D., Eatontown; age 69
A. Bradford Judd, M.D., Shrewsbury; age 59
Antonio Marotta, M.D., Little Silver; age 59
William J. Woodward, M.D., West Long Branch; age 67

Morris County

Walter J. Baziuk, M.D., Brookside; age 66
Sol C. Bershadsky, M.D., Madison; age 70
Donald J. Flaster, M.D., Morris Plains; age 56
James R. Merkel, M.D., Califon; age 65
Mary Louise T. White, M.D., Morristown; age 65

Ocean County

Joseph J. Camarda, M.D., Edenton, NC (formerly Lakehurst); age 68

Passaic County

Robert Canaan, M.D., Fair Lawn; age 76
Lewis L. Immerman, M.D., West Orange; age 62
Dominic A. Kujda, M.D., Pompton Plains; age 67
Stephen M. Liana, M.D., Lakehurst; age 81
George M. Meier, M.D., Butler; age 63
James W. Murphy, M.D., Pompton Plains; age 63
Louis Palmisano, M.D., Paterson; age 58
A. Gerard Peters, M.D., Wayne; age 73
Carl Rasin, M.D., Delray Beach, FL (formerly Passaic); age 71
Joseph S. Shapiro, M.D., Paterson; age 70
Howard W. Stier, M.D., Clifton; age 70

Salem County

Albert J. Sungenis, M.D., Highland, MD (formerly Pennsville); age 63

Somerset County

Alfred S. Conston, M.D., Somerville; age 70

Union County

James Brady, M.D., Westfield; age 65
William E. Ganss, M.D., Groton, VT (formerly Jamesburg); age 64
Joseph P. Greeley, M.D., Westfeld; age 66
Joseph E. Kalbacher, M.D., Hackettstown; age 66
Richard W. Lang, M.D., Mantoloking; age 66
Walter A. Lorenz, M.D., Peapack; age 69
Robert H. Null, M.D., Warren; age 69
Barry Schenk, M.D., Plainfield; age 54
Theresa A. Smith, M.D., Westfield; age 57
W. Arthur Staub, M.D., Palm Beach, FL (formerly Cranford); age 65
Margaret E. Symonds, M.D., New Vernon; age 68
John A. Waraksa, M.D., Berkeley Heights; age 55

The Reference Committee recommends that the nominations be approved.

HOUSE ACTION: Adopted. The nominations were approved.

Nominations for Emeritus Membership

(Reference Committee "B")

The following additional nominations for election to emeritus membership have been received:

Essex County

Michael A. Del Pomo, M.D., Atlantic Highlands; age 64

Hudson County

Joseph F. Corless, M.D., North Bergen; age 70

Samuel D. Critides, M.D., Glen Ridge; age 67

Dominic A. Mauriello, M.D., Jersey City; age 68

Olindo W. Rosanelli, M.D., Montague; age 66

Morris Schapiro, M.D., West Orange; age 70

The Reference Committee recommends that the nominations be approved.

HOUSE ACTION: Adopted. The nominations were approved.

1988 HOUSE OF DELEGATES

Medical Society of New Jersey
222nd Annual Meeting
April 28 - May 1, 1988

REFERENCE COMMITTEE "C"

REPORT

Council on Medical Services
Resolutions #2, #5, #6, #7, #8, #9,
#10, #11, #12, #19, #21E, #23E

MEMBERS

Harold R. Reeve, MD, Chairman
Louis G. Fares, II, MD
Paul C. Royce, MD
Paul J. Schneider, MD
Bessie M. Sullivan, MD
John C. Baker, MD, Alternate Member

Council on Medical Services

JOSEPH W. FLEISHER, MD, CHAIRMAN

(Reference Committee "C")

1. **Blue Shield's Medallion Program.** Upon the request of the Board of Trustees, the Council on Medical Services reviewed certain aspects of the Blue Shield Medallion Program, at which time Charles L. Cunniff, MD, vice-president, Medical Affairs, Blue Cross-Blue Shield presented an informative report on the program.

After careful deliberation, the following recommendations were submitted to and approved by the Board of Trustees at its meeting on November 15, 1987:

- a. That the Society reject the proposal to advise the Society's membership that it is in their best interest to consider rejecting "participating" status in Blue Shield; and in its place, a balanced presentation in a general fact sheet format be released to assist the membership in rendering their own individual decisions regarding participation.
- b. That the Board be advised that the Council is opposed to the concept of differential/discriminatory reimbursements for identical services rendered whether a physician is participating or not, and saw no legal remedy possible. [This recommendation was amended and approved.]
- c. That the Board seek an independent legal opinion to determine whether the Blue Shield position that Pace-participants also are participants in Medallion is valid. The Board did engage a firm to research that point. It was determined that the Blue Shield action is lawful.
- d. That the Board should further explore the January 1980 directive by former Insurance Commissioner Sheeran, directing Blue Shield to include its membership of participating physicians in all their programs, and that if it is found that the directive requires Blue Shield to do this, legislative or administrative relief should be sought.

The opinion from outside counsel confirmed the validity of the above directive. The Society will discuss the matter with the commissioner of insurance.

2. **Resolution #30E—Uniform National Standards of Care.** Upon the request of the Board of Trustees, the Council studied 1987 Resolution #30E—Uniform National Standards of Care. After careful consideration, the Council submitted the following recommendation which the Board of Trustees approved unanimously as amended at its meeting on November 15, 1987:

That because of the thousands of variables, uniform standards of care cannot be formulated *at this time by our Society*. [Italics denotes amendment.]

3. **Resolution #13—Disability Benefit Forms.** The 1987 Resolution #13, Disability Benefit Forms, was referred to the Council on Medical Services for further study and development of appropriate methodology. This matter is under consideration by the Council and a report will be forwarded to the Board of Trustees as soon as possible.

The Reference Committee was concerned that there was no testimony regarding the content of the report of the Council on Medical Services. The Reference Committee felt that there were several critical issues which should have been addressed with regard to the Blue Shield Medallion Program.

The Reference Committee recommends that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

Resolution #2

Introduced by: Essex County Medical Society
Subject: Repeal PRO Law
Referred to: Reference Committee "C"

Whereas, the federal PRO law is both a subtle, implicit, and an actively explicit barrier between the patient and the attending physician's best judgment of the patient's medical management; and

Whereas, the federal PRO makes patently unfair decisions to patients and to their physicians by use of retrospective observations totally unavailable to and unpredictable by the physicians responsible for immediate medical decisions; and

Whereas, the federal PRO, by its adverse decisions, often unfairly denigrates the attending physician's reputation for professional competency and honesty in the eyes of his patients; and

Whereas, the federal PRO often does not provide due process to the attending physician regarding adverse decisions; and

Whereas, the federal PRO, by law, must make decisions from a patient's record which do not adequately account for the clinical impressions, judgment, and instincts of the attending physician and recognize that the art of medicine cannot be scientifically measured and rarely articulated; now therefore be it

Resolved, that the Medical Society of New Jersey adopt a position for the repeal of the federal PRO law; and be it further

Resolved, that the Medical Society of New Jersey place a resolution to this effect before the June annual meeting of the AMA so that they actively may seek the repeal of this law.

There was testimony expressing marked dissatisfaction with the present PRO system and for this reason the Reference Committee suggested the insertion of an additional resolved.

The Reference Committee recommends the addition of the following resolved immediately after the first resolved:

Resolved, that the AMA, in conjunction with the state medical societies and the specialty societies, formulate an alternative form of review to comply with the intent of the federal law; and be it further

HOUSE ACTION: Not adopted.

The Reference Committee recommends that Resolution #2 be adopted as amended.

HOUSE ACTION: Not adopted. Resolution #2 was adopted in its original form.

Resolution #5

Introduced by: Hospital Medical Staff Section
Subject: Accountability of Claim Review Workers
Referred to: Reference Committee "C"

Whereas, third-party payors are becoming increasingly involved in decision making in regard to testing, hospital admissions, and procedures for patients; and

Whereas, these decisions appear to be made by nonphysicians; and

Whereas, these decisions can greatly affect quality of care; and

Whereas, the decisions seem to be made more on controlling costs than on quality of care; now therefore be it

Resolved, that MSNJ encourage the New Jersey Board of Medical Examiners to consider that those making decisions (either physician or nonphysician) with regard to *payment for* testing, hospital admissions, and procedures for patients should be held accountable in the same way as the treating physician is held accountable for the care of the patient.

The Reference Committee heard testimony that claim review organizations are making patient care decisions, which are, in essence, the practice of medicine, and therefore these organizations must be responsible for the patient care decisions they make.

The Reference Committee recommends that the resolved be deleted and amended to read as follows:

Resolved, that MSNJ encourage the New Jersey Board of Medical Examiners to consider that those making patient care decisions (physicians, nonphysicians, or corporate entities) should be held accountable in the same way as the treating physician for the care of the patient.

HOUSE ACTION: Not adopted.

The Reference Committee recommends that Resolution #5 be adopted as amended.

HOUSE ACTION: Not adopted. Resolution #5 was adopted as amended by the House (*italics indicate amendments*).

Resolution #6

Introduced by: Hospital Medical Staff Section
Subject: ~~Billing for Multiple Claim Forms~~ *Preparation of Medical Information for Third Parties*
Referred to: Reference Committee "C"

~~Resolved, that MSNJ remind its membership that except for one claim form, they have the right to bill appropriately for preparation of medical information for third parties.~~

Resolved, that MSNJ remind its membership that except for claim forms, they have the right to bill third parties appropriately for preparation of medical information.

The Reference Committee recommends that the subject of Resolution #6 be changed to "Billing for Preparation of Medical Information for Third Parties."

HOUSE ACTION: Adopted. The subject of Resolution #6 was changed (italics indicate amendments).

The Reference Committee recommends that the resolved be deleted and amended (italics indicate amendments).

HOUSE ACTION: Adopted. The resolved was deleted and amended.

The Reference Committee recommends that Resolution #6 be adopted as amended.

HOUSE ACTION: Adopted. Resolution #6 was adopted as amended by the Reference Committee.

Resolution #7

Introduced by: Hospital Medical Staff Section
Subject: Confidentiality of Medical Information
Referred to: Reference Committee "C"

Resolved, that MSNJ remind its membership that it is unethical to release patient information without written authorization from the patient.

The Reference Committee recommended that Resolution #7 be adopted with the following editorial change: delete the word "unethical" and substitute "illegal."

Seymour F. Kuvin, MD, suggested the following amendment for Resolution #7:

Resolved, that MSNJ remind its membership that it is illegal to release patient information, unless there is an imminent danger to others, other written authorization from the patient.

HOUSE ACTION: Not adopted. Resolution #7 and all suggested amendments were referred to the Board of Trustees for action.

Resolution #8

Introduced by: Hospital Medical Staff Section
Subject: Unauthorized Release of Medical Information
Referred to: Reference Committee "C"

Resolved, that MSNJ remind its membership that they have the right to say "no" to any request for medical information except from the patient or his designated legal representative.

The Reference Committee recommends that Resolution #8 be adopted with the following editorial change: delete the word "legal" before the word "representative."

Seymour F. Kuvin, MD, suggested the following amendment for Resolution #8:

Resolved, that MSNJ remind its membership that they have the right to say "no" to any request for medical information except from the patient or his designated legal representative, unless there is imminent danger to others.

HOUSE ACTION: Not adopted. Resolution #8 and all suggested amendments were referred to the Board of Trustees for action.

Resolution #9

Introduced by: Hospital Medical Staff Section
Subject: Certification of Review Organizations
Referred to: Reference Committee "C"

Whereas, providers of medical services, both physicians and hospitals, recently have been deluged by various private insurers for the purpose of effecting concurrent review of medical necessity; and

Whereas, such reviews definitely are self-serving for the insurance companies; and

Whereas, the New Jersey Department of Health has officially recognized only certain utilization review organizations to perform such tasks; now therefore be it

Resolved, that MSNJ seek appropriate regulatory or legislative efforts to assure that all reimbursement and approval reviews are conducted by utilization review organizations approved by the New Jersey Department of Health.

Resolution #9 addresses an important problem which is complex and the Reference Committee feels that further consideration is needed.

The Reference Committee recommends that Resolution #9 be referred to the Board of Trustees for further study and action.

HOUSE ACTION: Adopted. Resolution #9 was referred to the Board of Trustees for further study and action.

Resolution #10

Introduced by: Anthony P. Caggiano, Jr, MD, Delegate, Essex County
Subject: Remove Alleged Birth-Related Neurological Injuries from Tort Law
Referred to: Reference Committee "C"

Whereas, professional liability insurance for obstetricians and gynecologists is becoming more difficult to secure and, when available, only at extremely high premiums; and

Whereas, 25 percent of ob/gyn physicians could not obtain professional liability coverage in Virginia; and

Whereas, Virginia, followed by Florida, sought an innovative approach to the problem and removed birth-related neurological injuries from the tort system; and

Whereas, ob/gyn physicians then became insurable for malpractice as a coverable surgical specialty; and

Whereas, this mechanism could apply, in the future, to other specialties or procedures; now therefore be it

Resolved, that the Medical Society of New Jersey actively seek legislation similar to the 1987 Virginia Birth-Related Neurological Injury Compensation Act; *and be it further*

Resolved, *that the Medical Society of New Jersey and the Medical Inter-Insurance Exchange of New Jersey look at the possibility of developing this concept for other types of professional liability injuries.*

The Reference Committee heard testimony emphasizing the plight of ob/gyn specialists and feels that the Resolution has merit and possible application to other areas of tort law.

The Reference Committee recommends the addition of four words and a resolved (noted in italics).

HOUSE ACTION: Adopted.

The Reference Committee recommends that Resolution #10 as amended be referred to the Board of Trustees for study and action.

HOUSE ACTION: Adopted. Resolution #10 was adopted as amended and referred to the Board of Trustees for study and action.

Resolution # 11

Introduced by: Union County Medical Society
Subject: Telephone Information
Referred to: Reference Committee "C"

Whereas, over the past year it has become increasingly common for health care agencies to request diagnoses and treatment plans from physicians over the telephone; and

Whereas, these agencies have been persistently more demanding in the pursuit of information; and

Whereas, these agencies, at times, have threatened to withhold benefits if the information was not provided; and

Whereas, these agencies are operating from bases outside the state of New Jersey; now therefore be it

Resolved, that this is the position of the Medical Society of New Jersey that it is unethical for member physicians to provide information over the telephone concerning a patient, other than to the patient, his family, or lawful representatives; and be it further

Resolved, that the proper response of a physician to such a request for telephone information would be to request a written authorization from the patient and a written explanation of what is necessary from the agency.

The Reference Committee agreed with the intent of Resolution #11, but felt that specific changes were necessary to clarify the concept.

The Reference Committee recommends that the first resolved be deleted and amended to read as follows:

Resolved, that it is the position of the Medical Society of New Jersey that it is improper for a member physician to provide patient information over the telephone to third-party carriers or health care agencies unless the patient has given written authorization.

HOUSE ACTION: Not adopted.

The Reference Committee recommends that the second resolved be deleted.

HOUSE ACTION: Not adopted.

The Reference Committee recommends that Resolution #11 be adopted as amended.

Seymour F. Kuvin, MD, suggested the following amendment for Resolution #11:

Resolved, that it is the position of the Medical Society of New Jersey that it is unethical for member physicians to provide information over the telephone concerning a patient, other than to the patient, his family, or lawful representatives unless there is an imminent danger to others; and be it further

HOUSE ACTION: Not adopted. Resolution #11 and all suggested amendments were referred to the Board of Trustees for action.

Resolution #12

Introduced by: Union County Medical Society
Subject: Reimbursement for Extraordinary Forms
Referred to: Reference Committee "C"

Whereas, it has become increasingly popular for health care agencies to request information over the telephone; and

Whereas, it is unethical for a physician to supply such information over the telephone; and

Whereas, it is the position of the Medical Society of New Jersey that it is appropriate to supply this information only on written authorization from the patient, and in written form; now therefore be it

Resolved, that it is appropriate and proper for the physician to charge a reasonable fee for completion of this type of extraordinary information form; and be it further

Resolved, that a request for information by any agency be considered an extraordinary form for which a fee can justifiably be requested.

The Reference Committee felt that Resolution #12 addressed an important issue which already had been covered by Resolution #6.

The Reference Committee recommends that Resolution #12 be rejected.

HOUSE ACTION: Adopted. Resolution #12 was rejected.

Resolution #19

Introduced by: Bergen County Medical Society
Subject: Physician Notification of Proposed Medicare Changes
Referred to: Reference Committee "C"

Whereas, Medicare reimbursement for all medical services is changing due to complicated unforeseen legislative and economic needs; and

Whereas, patient care and medical practice require current and appropriate medical laboratory testing and procedures; and

Whereas, physicians using or considering the use of their own laboratory facilities and/or purchase of new equipment need honest and current Medicare reimbursement information; and

Whereas, Prudential Medicare has unilaterally, and without any notification to physicians, changed Medicare reimbursement policies, now therefore be it

~~Resolved, that the Part B Medicare carrier be requested to notify the Medical Society of New Jersey and appropriate medical specialty societies six months in advance of anticipated revenue-saving reimbursement policy changes to allow time for comment and discussion; and be it further~~

~~Resolved, that Prudential Medicare be requested to notify all physicians in a forthright and clear manner three months in advance of regulated changes in reimbursement policies so that adequate time is allowed to prepare for these changes.~~

Resolved, that the Health Care Financing Administration be requested to notify the Medical Society of New Jersey and appropriate medical specialty societies six months in advance of anticipated revenue-saving reimbursement policy changes to allow time for comment and discussion; and be it further

Resolved, that the Health Care Financing Administration be requested to notify all physicians in a forthright and clear manner three months in advance of regulated changes in reimbursement policies so that adequate time is allowed to prepare for these changes.

The Reference Committee heard testimony on both sides of this issue but feels that implementation is not feasible since the Part B Medicare Carrier does not receive timely information from the Health Care Financing Administration.

The Reference Committee recommends that Resolution #19 be rejected.

HOUSE ACTION: Not adopted. Resolution #19 was adopted as amended by the House.

Resolution #21E

Introduced by: Union County Medical Society
Subject: Medicare Deductibles and Co-Payments
Referred to: Reference Committee "C"

Whereas, federal law requires physicians when accepting Medicare assignment to bill for the deductible and co-payment; and

Whereas, the public in many instances assumes that "accepting assignment" means no additional bill from physicians; now therefore be it

~~—Resolved, that the AMA petition the federal government to appropriately and adequately apprise the public that when a physician accepts Medicare assignment, the physician is required by law to bill for deductibles and co-payments.~~

Resolved, that the AMA petition the federal government to appropriately and adequately apprise the public that physicians accepting Medicare assignments are required by law to bill for deductibles and co-payments.

The Reference Committee recommends that the resolved be deleted and amended (italics indicate amendment).

HOUSE ACTION: Adopted.

The Reference Committee recommends that Resolution #21E be adopted as amended.

HOUSE ACTION: Adopted. Resolution #21E was adopted as amended by the Reference Committee.

Resolution # 23E

Introduced by: Atlantic, Burlington, Camden, and Gloucester County Medical Societies
Subject: Adjustment of Medicaid Fees
Referred to: Reference Committee "C"

Whereas, Medicaid fees have not been increased since 1971; and
Whereas, there are few physicians accepting Medicaid patients; and
Whereas, there is an increased need for medical care to the indigent; and
Whereas, the present Medicaid fees are unrealistically low; and
Whereas, Medicaid patients frequently receive medical care at emergency centers at a higher cost to the state; now therefore be it

~~**Resolved**, that the Medical Society of New Jersey direct its efforts toward encouraging appropriate state authorities to adjust Medicaid reimbursement to a level comparable with Medicare reimbursement for physicians' services.~~

***Resolved**, that the Medical Society of New Jersey reinforce its previous efforts (Resolution #2—1981) toward encouraging appropriate state authorities to adjust Medicaid reimbursement to a level comparable with usual, customary, and reasonable reimbursement for physicians' services; and be it further*

***Resolved**, that physicians be reimbursed for all costs related to the additional charges necessitated by federally mandated surcharges for biological materials and their administration since January 1, 1988; and be it further*

***Resolved**, that the Medical Society of New Jersey support and encourage to its fullest capacity the continuing efforts of the Committee on Medicaid.*

The Reference Committee heard lengthy discussion on the critical state of medical care for the indigent population of the state due in large measure to the penurious policy of the state legislature. It applauds the tireless efforts of the Committee on Medicaid in functioning under the most frustrating circumstances.

The Reference Committee recommends that the first resolved be amended (noted in italics).

HOUSE ACTION: Adopted.

The Reference Committee recommends the addition of another resolved (the third resolved—noted in italics).

HOUSE ACTION: Adopted.

The Reference Committee recommends that Resolution #23E be adopted as amended.

HOUSE ACTION: Adopted. Resolution # 23E was adopted as amended by the House; the House adopted the middle Resolved.

1988 HOUSE OF DELEGATES

**Medical Society of New Jersey
222nd Annual Meeting
April 28 – May 1, 1988**

REFERENCE COMMITTEE “D”

REPORT

**Council on Legislation
Council on Public Relations
Resolutions #1, #13, #16, #17**

MEMBERS

**Robert L. Wegryn, MD, Chairman
Stephen J. Abrams, MD
Natalio Damien, MD
Michael R. Henderson, MD
Rose P. Prystowsky, MD
Aiden J. Doyle, MD, Alternate Member**

Council on Legislation

IRVING P. RATNER, MD, CHAIRMAN

(Reference Committee "D")

This report presents a summary of the ultimate status of legislative measures of the 202nd Legislature. The Council's operations, together with a cumulative report of MSNJ's official positions on current legislation, are reflected regularly in the official bulletins dispatched to state legislative keymen and to component societies, and in items published in the Membership Newsletter in *NEW JERSEY MEDICINE*, the journal of the Medical Society of New Jersey.

The Council on Legislation continues to invite an official representative from each specialty society to all Council meetings. A notice announcing the date of each of the Council's meetings also is sent to all MSNJ Official Intermediaries with New Jersey specialty societies.

The Council urges that more representatives attend its meetings so that it may have the benefit of the timely thinking of specialty societies concerning proposed legislation affecting the specialty fields.

The Council also invites the Chairman or representatives of each Council and Standing Committee to attend the legislative meetings. Recent bylaw amendments make it possible for one Auxiliary member, one resident member, and one student member appointed by the President, to serve on the administrative councils and committees for a one-year term, to be full voting members of the representative council and committees.

Every other month there is a special section in *NEW JERSEY MEDICINE* dealing with legislative and regulatory updates. The status of all active MSNJ legislative matters is detailed.

Of the bills reported to the House from the First and Second Sessions of the 202nd Legislature the following were signed into law:

S-1089—Provides immunity from liability for medical personnel who take breath, blood, or urine samples at request of police. **Approved.**

S-1316—Creates a task force on adolescent pregnancy to make recommendations to the governor and the Legislature. **Approved.**

S-1990—Authorizes the Commissioner of Human Services to establish a confidential reporting system by practitioners to the Commission for the Blind. **Approved.**

S-2708—Reduces damages in personal injury cases by any collateral sources of income. **Approved.**

S-2709—Provides for arbitration of tort claims when a judge determines the amount in controversy is \$20,000 or less. **Approved.**

A-1095—Requires all hospital service contracts to include services and products rendered at home under the supervision of a state-approved hemophilia treatment center. **Approved.**

A-1096—Same as **A-1095**—applies to group health insurance contracts. **Approved.**

A-1097—Same as **A-1096**—applies to individual health insurance contracts. **Approved.**

A-1473—Adds medical physics and epidemiology to the types of training of members of the Radiation Protection Commission. Also adds two new members to the Commission. **Approved.**

A-1813—Revises the law concerning commitments to psychiatric facilities. **Approved.**

A-2467—Extends the "Good Samaritan Act" to first aid and ambulance squad members. **Approved.**

A-2733—Provides specialized services to low-income women (prenatal) and their babies (postpartum) in high-risk pregnancies. **Approved.**

A-3017—Allows nursing homes to expand their capacity within a five-year period by no more than ten beds or 10 percent without obtaining a certificate of need. **Approved.**

S-1979—Eliminates the requirement that the prescriber's address and registry number be included on the prescription label. **Active Support.**

A-3434—Amends the Insurance Fraud and Prevention Act to eliminate the verification of medical bills submitted with insurance claims. **Active Support.**

AJR-49—Directs the Commissioner of Health to study and report the feasibility of health enterprise zones. **Active Support.**

S-977—Authorizes the State Board of Higher Education to contract with an out-of-state medical school to accept two to four minority students per class. Following licensure, the students must serve three years in a medically underserved area of New Jersey. **Disapproved.**

S-1696—Requires the Department of Health to make available to physicians a pamphlet on the adverse effects and benefits of pertussis vaccination. The physician is to maintain appropriate documentation as to vaccination and consent. Major adverse reactions are to be reported to the manufacturer. **Disapproved.**

S-2372—Establishes local health planning to replace the HSA system. Funds are raised by taxing hospitals on patient volume. **Disapproved.**

S-2484—Provides for a legal services plan to assist Medicare beneficiaries in appealing denials of benefits. **Disapproved.**

S-600—Requires every physician attending a woman at the time of delivery, miscarriage, abortion, or during the prenatal period to perform an Rh test. If the test is Rh negative the physician shall, within 24 hours of receipt of the results, advise the woman of its significance and the availability of preventive treatment. **Active Opposition.**

S-1181—Requires hospitals to adopt policies and procedures which ensure newborns receive nourishment and care consistent with accepted medical standards. **Active Opposition.**

S-2703—Modifies the application of joint and several liability in tort actions. (In favor of MSNJ's **Active Support** of A-2401.) **Active Opposition.**

The following is a list of bills of the 1986-87 Legislature that were introduced after the meeting of the 1987 House of Delegates.

SENATE

S-1276-Contillo—Tobacco Sales to Minors. Prohibits the sale of tobacco and tobacco products to minors. **Approved.**

S-2137-McManimon—Health Planning. Creates a "local health planning" system to operate the certificate of need apparatus. The agencies would be funded by a special tax on hospitals. **Active Opposition,** MSNJ is opposed to governmental mandated health planning.

S-2387-DiFrancesco—Temporary Disability. Protects pregnant workers and others by providing mandatory job guarantees and health benefits for up to 26 weeks in a given year. **No Action.**

S-2392-DiFrancesco—Temporary Disability. Provides that parents of newly born, adopted, or seriously ill children will be entitled to leave from employment and guarantees employment security. Protected leave would be 26 weeks in a 24-month period. **No Action.**

S-2424-Codey—Pharmacy (same as A-2559). Prohibits certain health care institutions from conducting a retail pharmacy. **Active Opposition,** in accordance with Board of Trustees' actions (4-12-87). This bill is anticonsumer and detrimental to the future efforts of hospitals and physicians to diversify services in order to meet cost containment goals.

S-2960-Ewing—AIDS. Requires persons suspected of venereal disease to submit to HLTIV-III tests; requires applicants for marriage licenses to be tested and the physician to notify them in writing of the results on a form developed by the Department of Health; requires physicians to certify that they have tested applicants and notified them of the results. **Action Deferred,** pending further information from MSNJ's AIDS/HIV Task Force.

S-3009-Dalton—Emergency 911. Provides for planning and implementation of a 911 system throughout the state. **Conditional Approval,** pending amendment to the bill that would transfer the financing mechanism from community business phone users to the state government.

S-3013-McNamara—Medicaid. Expands the medically needy program to cover inpatient care. **Approved.**

S-3019-Pallone—Ocean Environment. Calls for the Department of Health and the Department of Environmental Protection to undertake a health impact study on New Jersey coastal waters. Appropriates \$1 million for the study. **Approved.**

S-3164-Lesniak—Medical Licensure. Deletes the requirement that physicians attend at least two years of college. **Disapproved,** because the existing statute that applies to educational requirements in New Jersey should not be weakened.

S-3170-Dorsey—Political Contributions (same as A-4374). Limits PAC contributions to \$2,500 per candidate per calendar year. **No Action.**

S-3177-Rand—Prescription Drugs. Prohibits mail order prescription drugs in state employee programs. **Conditional Approval,** pending amendment to the bill that would prohibit mail order drug dispensing unless they comply with all New Jersey drug dispensing regulations.

S-3233-Ewing—AIDS. Requires inmates in correctional institutions to be tested for AIDS. **Action Deferred,** pending further information from the AIDS/HIV Task Force.

S-3256-Cardinale—Healthy Lifestyles. Requires health insurers to give financial incentives for healthy lifestyles under insurance contracts and to offer wellness plans approved by the Commissioner of Insurance and Commissioner of Health. **Conditional Approval,** pending amendment to include periodic health care examinations.

S-3284-Zimmer—Emergency Medical Technicians. Permits emergency medical technicians certified by the Commissioner of Health as an EMT-D to perform cardiac defibrillation. **Active Support.**

S-3288-Bassano—Audiologists. Deletes the requirement that audiologists and speech therapists must pass a national examination. **Action Deferred,** pending further information from the New Jersey Academy of Ophthalmology and Otolaryngology.

S-3302-Feldman—Surrogate Parenting. Establishes a commission to study surrogate parenting. **Conditional Approval,** pending inclusion of MSNJ-appointed physician on the Commission.

S-3320-McManimon—Nursing Supply. Creates a commission to study the nursing supply problem.

No medical representation is included. **Conditional Approval**, pending inclusion of physician on Commission.

S-3352-VanWagner—Civil Immunity. Grants civil immunity to counselors and psychotherapists for disclosing a patient's potential for violence in certain situations. **Conditional Approval**, pending inclusion of physician in psychotherapy section of bill.

S-3381-Zane—Auto Insurance. Provides for certain amendments to the no-fault law. Establishes a medical fee schedule that incorporates the fees of 90 percent of the practitioners within a given region. **No Action (Conditional Veto).**

S-3390-Rand—Southern New Jersey Children's Hospital. Designates Cooper Hospital as the "Southern New Jersey Children's Hospital" provided a majority of the acute care hospitals providing inpatient pediatric care in southern New Jersey agree to refer to Cooper. (This bill substituted by **A-4073**.) **Approved.**

S-3414-McManimon—AIDS. Requires that funeral directors be notified in writing if a patient had a communicable disease which requires that precautions be taken. **Conditional Approval**, pending amendment to assure confidentiality of information by the funeral director.

S-3429-Dalton—Medical Fee Schedule (Auto Insurance). Provides that the Commissioner of Insurance shall promulgate a fee schedule at the 90th percentile. The schedules are to be reviewed biannually. **No Action.**

S-3475-Ambrosio—Recovery of Burial Expenses. Provides that noneconomic damages in the wrongful death of a minor shall be limited to \$100,000. **Action Deferred**, pending further information from the Medical Inter-Insurance Exchange of New Jersey.

S-3482—AIDS. Requires the Department of Health to adopt rules to assure that hospitals accept their fair share of patients with AIDS or ARC. **No Action.**

S-3498-Cardinale—Osteoporosis (same as A-3707). Creates a 15-member Commission to study services to patients with osteoporosis. Five of the members shall be health care professionals. **No Action.**

S-3500-McManimon—Disability Determinations (same as A-4465). Allows psychologists to certify disability. **Active Opposition**, the determination of disability certification is a medical decision.

S-3510-Dalton—Emergency Medical Services. Extends the Emergency Medical Services Study Commission another four months. The Commission in its first phase report has recommended a statewide 911 system. **Approved.**

S-3518-Haines—HMO. Provides that if an HMO and a contracting health care facility do not renew their contract, it shall remain in force four months following the contract expiration date in order to allow enrollees the opportunity for normal transition. **Conditional Approval**, pending an amendment to provide that the same notification be forwarded to providers as well as enrollees.

S-3633-Lipman—"Wellness". Requires health insurers to offer wellness incentives. **No Action.**

S-3651-DiFrancesco—Involuntary Commitments. Assures patients in short-term psychiatric facilities and screening services certain civil rights. **Action Deferred**, pending further information from MSNJ's Council on Mental Health.

S-3682-Gormley—Medical Waste Disposal. Imposes strict liability on hospitals and health care facilities for the damages caused by the discharge of waste into the ocean or fresh waters of the state. **Action Deferred**, pending further information from MSNJ's Council on Public Health and the Medical Inter-Insurance Exchange of New Jersey concerning the joint and several liability referred to in the bill statement.

S-3696-McManimon—Local Health Planning. Appropriates \$650,000 to fund local health planning. **Active Opposition**, mandated planning has not proved effective and should not be continued. Eleven states plus the federal government have deleted it.

ASSEMBLY

A-2559-Felice—Pharmacy (same as S-2424). Prohibits institutions from operating retail pharmacies within 1,500 feet of their facility. **Active Opposition**, in accordance with Board of Trustees' actions (4-12-87). This bill is anticonsumer and detrimental to the future efforts of hospitals and physicians to diversify services in order to meet cost-containment goals. **Conditional Veto.**

S-2682-Stuhltrager—Minors. Prohibits the sale of tobacco to minors. **Approved.**

A-3079-Paterniti—Temporary Disability. Provides that jobs of persons on temporary disability must be protected for 26 weeks. **Disapproved**, this bill would have a significant adverse impact on small businesses.

A-3081-Catrillo—Temporary Leave. Provides that positions of parents of seriously ill children may take protected leave of up to 26 weeks within a two-year period. **No Action.**

A-3683-Martin—Nursing Education. Directs Rutgers to establish a doctoral program in nursing. **Disapproved**, the trustees of the University should determine what degrees should be offered.

A-3707-Paterniti—Osteoporosis (same as S-3498). Establishes a commission (15 members) to compile and analyze data on osteoporosis, develop educational programs, and assist local health agencies in public education. **No Action.**

A-3711-Zecker—No Fault. Amends the no-fault law in several areas. Requires carriers to conduct utilization review and to engage in managed care. **Disapproved**, third-party carriers are denying patients access to needed care. This legislation would aggravate that situation.

A-3719-Cooper—Withholding or Withdrawing Treatment in Terminal Illness. Allows competent adults to issue a directive that provides they shall not be artificially sustained during a terminal condition.

No definition is provided for terminal condition. **Action Deferred**, pending report of the Governor's Commission on Biomedical Ethics.

A-3724-Catrillo—AIDS. Requires the Department of Health to institute a mobile educational program on AIDS for IV drug users. **Action Deferred**, pending further information from MSNJ's HIV/AIDS Task Force.

A-3725-Singer—Child Abuse. Establishes a child abuse diagnostic center in southern New Jersey. **Approved.**

A-3744-Ogden—Communicable Disease. Requires health care facilities to notify first aid, ambulance, or rescue squads that the patient they are transporting has a communicable disease when that fact is known to the facility. **Approved.**

A-3751-Loveys—Structured Payments in Tort (same as A-4615). Requires structured payments when future damages exceed \$200,000 by means of an annuity contract. **Active Support.**

A-3754-Doyle—Emergency Services. Requires volunteer emergency personnel to be certified either through the State First Aid Council or the Department of Health. **Approved.**

A-3777-Colburn—Certificate of Need (CON). Allows hospitals to undertake outpatient projects costing no more than \$2,000,000 without obtaining a certificate of need. **Active Support.**

A-3801-Kline—AIDS (Health Insurance). Prohibits the denial of insurance to persons with AIDS. **Action Deferred**, pending further information from MSNJ's HIV/AIDS Task Force.

A-3817-Kline—AIDS (Funeral Directors). Requires doctors, nurses, or the medical examiner to notify the funeral director in writing if the decedent had or was suspected of suffering from a communicable disease. **Conditional Approval**, pending amendment to assure confidentiality of information by the funeral director. Refer to MSNJ's HIV/AIDS Task Force. **(Absolute Veto.)**

A-3865-Kosco—Prosthetists and Orthotists. Licenses and regulates prosthetists and orthotists through a multidisciplinary professional board with the Division of Professional Boards. **Disapproved**, there is no indication that public interest will be served by licensing these technicians.

A-3882-Moran—Prescription Drugs (same as S-3177). Prohibits mail order prescription drugs in any state benefits program for public employees. **Conditional Approval**, pending amendment to the bill that would prohibit mail order drug dispensing unless they comply with all New Jersey drug dispensing regulations.

A-3933-Felice—Medicaid. Increases fees for professional health services to Medicaid recipients by 10 percent. **Conditional Approval**, Medicaid fees are an embarrassment and should be raised to the level of Medicare.

A-3935-Singer—Medicare. Requires the Commissioner of Health to study the senior medical courtesy program and to file a report by January 1, 1988. **No Action.**

A-3948-Kline—AIDS Reporting. Requires that patients with positive HTLV III be reported to the Department of Health within 72 hours. The Department shall institute contact tracing. All information is to be confidential. **Action Deferred**, pending further information from MSNJ's HIV/AIDS Task Force.

A-3965-Pelly—Impaired Professionals. Directs the Boards responsible for licensing certain but not all health professionals to institute impaired professional programs. Professional societies would contract with the respective boards to administer the program. There are no details regarding qualifications of personnel or funding. **No Action.**

A-3995-Gargiulo—Suicide (Elderly). Creates a 13-member commission to study the problem of suicide among the elderly. **Disapproved**, there are other sectors of our society that have a suicide rate higher than the elderly—to be meaningful, the study should include all ages.

A-4001-Collins—Nurses Supply (same as S-3320). Creates a commission to study the nursing supply problem. Does not include physician representation. **Conditional Approval**, pending inclusion of physician on Commission. **(Absolute Veto.)**

A-4013-Otowski—Mental Health. Assures persons receiving treatment on an involuntary basis in either a screening service of short-term facility of the same rights as patients who have been involuntarily committed to state or county psychiatric facilities. **Action Deferred**, pending further information from MSNJ's Council on Mental Health.

A-4043-Albohn—Audiologists. Deletes the requirement that audiologists and speech pathologists must pass a national examination. **Action Deferred**, pending further information from the New Jersey Academy of Ophthalmology and Otolaryngology.

A-4069-Kern—AIDS. Provides that anyone with AIDS who knows of their infection and commits an act of sexual penetration is guilty of a crime of the third degree. **Action Deferred**, pending further information from MSNJ's HIV/AIDS Task Force.

A-4073-Bryant—Southern New Jersey Children's Hospital (same as S-3390). Designates Cooper Hospital as the "southern New Jersey children's hospital" provided a majority of the acute care hospitals providing inpatient pediatric care in southern New Jersey agree to refer to Cooper. **(LAW c.299 (1987))**

A-4119-Zecker—County Medical Examiners. Requires the state to finance the county medical examiner system. **No Action.**

A-4138-Kavanaugh—Surrogate Parenting. Prohibits the payment of money for surrogate parenting purposes. **No Action.**

A-4161—Kavanaugh—Alcoholism and Drug Abuse. Creates a Governor's Council on Alcoholism and Drug Abuse. The Council will be the single state agency for alcohol and drug abuse; coordinates all state educational programs; develop and implement a master plan for treatment, prevention, research, and education. The Council will be in but not "of" the Department of Health. **Action Deferred**, pending further

information from MSNJ's Committee on Drug and Alcohol Abuse. Refer to MSNJ's HIV/AIDS Task Force.

A-4171-Kern—Council on Alcoholism and Drug Abuse. Similar to but not identical to A-4161. Does not reorganize the current agencies in state government as does A-4161. **Action Deferred**, pending further information from MSNJ's Committee on Drug and Alcohol Abuse. Refer to MSNJ's HIV/AIDS Task Force.

A-4182-Deverin—Medicaid. Extends Medicaid benefits for one year for employed patients after they have left Aid to Families with Dependent Children (AFDC) eligibility. (**LAW c.283 (1987)**)

A-4249-Villane—Environment. Requires the state government to study the health effects of chlorinated sewage in coastal waters. **Approved.**

A-4316-Randall—Adolescent Drug and Alcohol Abuse. Requires the Commissioner of Health to establish a 15-member task force to study and make recommendations regarding regulations for drug and alcohol treatment programs for adolescents. **Action Deferred**, pending further information from MSNJ's Committee on Drug and Alcohol Abuse.

A-4334-Colburn—HMO Contracts with Health Care Facilities. Provides that in the event that an HMO and a general hospital or other health care facility with which the HMO has a contract to provide services to its enrollees, are unable to agree on the terms of a new contract upon the expiration of the current contract, the health care facility and the HMO shall continue to abide by the terms of that contract for a period of four months from the date of expiration of the contract, during which time an enrollee of that HMO who has been receiving services from the health care facility under the terms of the previously existing contract may terminate his enrollment in the HMO and purchase health care benefits from another provider or insurance carrier. **Conditional Approval**, pending an amendment to provide that the same notification be forwarded to providers as well as enrollees.

A-4361-Kline—AIDS. Makes it a crime of the fourth degree for state employees to make an unauthorized disclosure of AIDS reports which have been submitted to the Department of Health. **Action Deferred**, pending further information on current statute concerning unauthorized disclosures.

A-4374-Donovan—Political Contributions (same as S-3170). Limits PAC contributions to \$2,500 per candidate per calendar year. **No Action.**

A-4432-Zecker—Civil Immunity. Permits certain nonprofit corporations to extend immunity to trustees, directors, officers, members, or employees when exercising judgment or discretion. **Approved.**

A-4435-Palaia—Emergency Medical Services (EMS). Appropriates \$1,500,000 to fund a statewide EMS network. **Approved.**

A-4465-Penn—Psychologists. Permits psychologists to certify disability under the temporary disability benefits law. **Active Opposition**, the determination of disability certification is a medical decision.

A-4466-Loveys—Joint and Several Liability. Eliminates joint and several liability except for environmental torts. **Active Support.**

A-4484-Rafferty—Collateral Sources of Income. Requires that collateral sources other than workers' compensation or life insurance shall be offset in personal injury actions. **No Action.**

A-4497-Villane—Medical Waste. Amends the hazardous waste act to include medical waste. **Action Deferred**, pending further information from MSNJ's Council on Public Health.

A-4515-Kern—Health Planning. Appropriates \$650,000 to fund local health planning. **Active Opposition**, mandated planning has not proved effective and should not be continued. Eleven states plus the federal government have deleted it.

A-4551-Deverin—Medicaid Fiscal Intermediaries. Provides that health service corporations and dental service corporations can qualify as intermediaries under Medicaid. **Approved.**

A-4615-Loveys—Structured Payments (same as A-3751). Provides for structured payments of future damages exceeding \$200,000. **Active Support.**

AR-141-Singer—Senior Medical Courtesy Program. Commends the Union and Ocean County Medical Societies for their senior medical courtesy programs. **Active Support.**

AR-143-Farragher—Medicare Fees. Requests Congress to raise fees to doctors participating in Medicare. **Active Support.**

AR-156-Kalik—Medicare—Catastrophic Illness. Requests Congress to provide Medicare recipients with catastrophic illness coverage. **Active Support.**

At the close of the 1986-87 Legislative Year all of the bills expired except those signed into law, vetoed, or filed by the Governor.

1987 HOUSE OF DELEGATES

Resolution #8—Physician Representation on Governmental Committees

Resolved, that the Medical Society of New Jersey continue to seek ways and means to have physicians placed on any governmental committee having to do with health problems and policies in the state of New Jersey.

Council on Legislation notes that recommendations of physicians being placed on governmental committees has already been implemented by MSNJ.

Resolution #12—First Aid Station in New Jersey Legislature

Resolved, that the Medical Society of New Jersey investigate the feasibility of offering, to both houses of the New Jersey Legislature, a rotational volunteer staffing of a first aid station for legislators.

The Council on Legislation appointed a representative from the New Jersey Chapter of the American College of Emergency Physicians, along with MSNJ's lobbyist to investigate and report back the feasibility of a first aid station in the New Jersey Legislature.

Resolution #29E—Physician Supervised Physical Therapy

Resolved, that the Council on Legislation of the Medical Society of New Jersey draft and seek to have introduced legislation that requires that physical therapy services may be rendered only under physician supervision.

The Council on Legislation accepted the foregoing information and noted that MSNJ is in the process of developing the appropriate language.

FEDERAL LEGISLATION

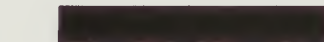
Summary of Medicare Reconciliation Provisions Relating to Payment for Physicians' Services Three-Month Freeze: During the three-month period ending March 31, 1988, prevailing and customary charge levels will be maintained at the levels in effect during 1987. Maximum Allowable Actual Charges (MAACs) for individual physicians' services furnished by nonparticipating physicians during the three-month period ending on March 31, 1988, will be the amount determined for 1987. (1988 MAACs will go into effect on April 1, 1988)

Physician Participation Agreements: Physicians who were participating physicians in 1987 will be entitled to terminate their 1987 agreement if they request to do so prior to December 31, 1987. Otherwise, all agreements in effect on December 31, 1987, will remain in effect for the three-month period ending on March 31, 1988. The effective period for participation agreements entered into for 1988 will be the nine-month period beginning on April 1, 1988, through December 31, 1988.

The Reference Committee noted that a vote of thanks was extended to the chairman, Doctor Irving P. Ratner, and members of the Council on Legislation, and to Mrs. June O'Hare, staff liaison to the Council, for the yeoman's work they are doing.

The Reference Committee recommends that the report be filed.

HOUSE ACTION: Adopted. The report was filed.



Supplemental Report #1

Council on Legislation

IRVING P. RATNER, MD, CHAIRMAN
(Reference Committee "D")

At 12 o'clock noon, Tuesday, January 12, 1988, the Senate and General Assembly met for organization of the First Annual Session of the 203rd New Jersey State Legislature. As the Legislature presently is constituted, the Senate has a total of 40 members consisting of 16 Republicans and 24 Democrats. The Assembly has a total of 80 members consisting of 42 Republicans and 38 Democrats. By means of official legislative bulletins, the Society's official legislative positions on all current state legislation regularly are called to the attention of legislators as well as component societies, cooperating agencies, county keymen, county society executive directors, and executive secretaries.

The Society has adopted the following regular range of official positions concerning proposed legislation:

- | | |
|-----------------------------------|--|
| Watch List | For all approved/disapproved legislation. |
| Active Support | All-out support for the measure. |
| Active Opposition | All-out opposition for the measure. |
| Note and File | For all no action legislation. |
| Conditional Approval | To indicate that the approval of the Society is conditional, subject to elimination of the unsatisfactory elements of the bill that are pointed out. |
| Action Deferred | Pending amendment that will have substantial impact on active support/active opposition legislation. |

Current Legislation

The Council offers this Supplemental Report #1 covering items dealt with since the compilation of its Annual Report.

Senate

S-6-Rand—Burn Registry and Reporting. Requires physicians treating a person with burns over 5 percent of his body to report the same to state or local police. Establishes a central burn registry in the Department of Community Affairs. **No Action.**

S-12-Rand—Banking and Insurance. Merges the Departments of Banking and Insurance into a single department with one commissioner. **No Action.**

S-48-Paterniti—Huntington's Disease. Establishes a Huntington's disease demonstration project within the Department of Health. The commissioner is to contract with a long-term care facility to operate a special 10 to 15 bed unit to measure the effectiveness of a special care program. **No Action.**

S-57-Paterniti—Professional Liability. Allows organizations of professionals to form associations to self-insure professional liability. The entities created would be under special regulatory control of the Insurance Department, but are not to be considered insurance companies. **Disapproved,** because the program would not protect the public by assuring adequate financing.

S-69-VanWagner—Wrongful Death. Expands recoverable damages in wrongful death actions to include emotional and social factors along with mental anguish. **Disapproved,** Supreme Court decisions in New Jersey have established a reasonable and workable format awarding damages in wrongful death actions. This bill would create an unwarranted expansion and escalate the cost of liability insurance without benefit to the public.

S-91-VanWagner—Home Health Care. This bill establishes an 18-month home health and community care demonstration program in the Department of Human Services. This program is designed to provide for the delivery of community-based home health care services by local home health and community care demonstration centers to functionally impaired persons who are at least 65 years of age or older or who are disabled pursuant to the Social Security Act.

This bill appropriates \$7,500,000 from the Casino Revenue Fund to the Department of Human Services and requires that of this sum, at least \$6,900,000 shall be allocated for funding to the Home Health and Community Care Demonstration Centers. **Approved.**

S-154-Lesniak—Medical Licensing Requirements. Deletes the requirement that physicians attend at least two years of college. **Disapproved,** because the existing statute that applies to educational requirements in New Jersey should not be weakened.

S-164-Zimmer—Emergency Medical Services. Creates an intermediate emergency unit which would allow an EMT-intermediate technician to provide advanced life support. **Disapproved,** in favor of MSNJ approval of S-190.

S-190-Zimmer—Emergency Medical Services. This bill permits an emergency medical technician (EMT) who has been certified by the commissioner of health to perform cardiac defibrillation, according to rules and regulations adopted by the commissioner. **Approved.**

S-213-O'Connor—Automobile Insurance. Assures that auto insurers cannot issue a policy with a medical deductible unless evidence of underlying medical insurance is provided. **Approved.**

S-216-O'Connor—Board of Chiropractic Examiners. Creates a separate licensing and regulatory board for chiropractic. **Active Opposition,** because there is no demonstrative need for this legislation. Chiropractics are adequately supervised under the auspices of the New Jersey SBME.

S-219-O'Connor—Nutritionists. Provides for the licensing and regulation of nutritionists through a Board of Nutrition within the Department of Law and Public Safety. **Active Opposition,** MSNJ generically is opposed to the creation of new professional boards.

S-263-Dumont—Statute of Limitations. Provides for a three-year statute of limitations, except for fraud, intentional concealment, or nontherapeutic or diagnostic purpose. Minors would have until age 11 on any injury prior to age 8. **Active Support.**

S-287-Dumont—Drug Abuse. Creates a commission to study the efficacy of mandating health insurance coverage of drug abuse treatment. **No Action.**

S-301-Dumont—Physical Therapy. Requires physical therapy treatment to be given under the supervision of a practitioner authorized to prescribe treatment. "Supervision" is defined as personally monitoring the progress of treatment and includes intermittent observation of treatment sessions. **Action Deferred,** pending further information from the New Jersey Academy of Family Practice, New Jersey Orthopaedic Society, and the New Jersey Society of Physical Medicine and Rehabilitation.

S-323-Costa—Nursing Homes. Requires skilled nursing homes or intermediate care facilities to have at least one registered nurse on duty 24 hours a day. **Disapproved,** current statute concerning nursing homes is adequate.

S-382-Lynch—Contact Lenses. Creates the profession of contact lens dispensing and fitting for nonphysicians and nonoptometrists. Licensure and regulation would be through the Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians. A prescription by a licensed optometrist or physician would be required. **Disapproved,** to that portion of the bill referring to the fitting of contact lenses because the public will unnecessarily be exposed to the risk of corneal abrasions and other types of eye injuries.

S-425-Haines—Insanity. Abolishes insanity as a defense for criminal conduct. Insanity would become a factor to consider for sentencing purposes. **No Action.**

S-442-Haines—HMOs. Provides that if an HMO and a contracting health care facility do not renew their contract, it shall remain in force for four months following the contract expiration date in order to allow enrollees the opportunity for normal transition. **Conditional Approval**, pending an amendment to provide that the same notification be forwarded to physicians as well as patients.

S-448-Bubba—Patient Rights. Would establish a bill of rights for hospital patients. The rights enumerated are essentially the developed common-law rights of patients in this state. The hospital administrator must supply written notice of these rights to all patients and post the notice in a conspicuous place in the facility. **Conditional Approval**, pending deletion of the litigation option of the bill, since it will produce unnecessary delays and cost patients extra legal expense. Further, there should be a clause or section added to the bill recognizing that patients have certain obligations to cooperate in their treatment and to comply with advice and directions.

S-470-Bubba—Surgical Consent. Requires physicians to personally present and obtain surgical consent forms and signatures. The form shall state the name of any assisting physician that performs surgery under the supervision of the attending. **Active Opposition**, this procedure relates to physician/patient relationship. It should not be a matter of licensure law. It is well addressed in civil and regulatory law.

S-490-Bubba—Surgical Consent. Requires express written consent to surgery except in cases of physical or mental incapacity or emergencies. The State Board, after consultation with the Health Department, the Medical Society, and the Hospital Association shall prescribe the consent forms which shall be used by physicians. **Conditional Approval**, pending further clarification of the bill from the sponsor, amendment inserting "operative" procedure in place of "surgical" procedure, and further information regarding the bill from the New Jersey Chapter, American College of Surgeons as to what impact this legislation would have on them.

S-545-Brown—Conflict of Interest. Prohibits participation by legislators in passage of legislation in which they have a personal interest. **No Action.**

S-550-Brown—Ombudsman for Children. Creates an office of ombudsman to monitor services rendered to children through the Department of Human Services. **Action Deferred**, pending further information from the New Jersey Academy of Pediatrics.

S-554-Brown—DYFS Study Commission. Establishes a 15-member commission to study and report on the operation of the Division of Youth and Family Services. **Conditional Approval**, pending the inclusion of a physician on the Commission.

S-634-Cowan—Licensing Board Immunity. Expands immunity from antitrust suits to licensing boards to include their actions regarding admittance to a profession, suspension, and revocation of licenses. **Approved.**

S-687-Laskin—Criminal Responsibility. Would abolish the defense of insanity, but would allow evidence of mental condition to be considered at time of sentencing. **No Action.**

S-692-Laskin—Repeals No-Fault Law. Repeals no-fault—reinstates the financial responsibility law and makes PIP (personal injury protection) optional. **Action Deferred**, pending further information from MSNJ's Council on Medical Services.

S-718-Codey—Certificate of Need. Amends the certificate of need to include physicians whenever a health service has been regionalized by regulation of the Department of Health. Regulation would terminate within three years, at which time, the commissioner could readopt the regulation. **Active Opposition**, there is no evidence the certificate of need concept is a valid regulatory item. It has proved to be ineffective in containing costs, it has stifled initiative, its expansion to intrude on the private practice of medicine is not warranted. Nationally, at least 11 states have repealed certificate of need legislation and a number of federal agencies (including the Department of Health and Human Services and the Federal Trade Commission) have called for its repeal.

S-722-Codey—Mental Health Coverage. Requires health insurers to provide coverage for mental illnesses. **Approved.**

S-723-Codey—Mental Health Coverage. Requires health insurers to provide coverage for mental illnesses. **Approved.**

S-724-Codey—Mental Health Coverage. Requires health insurers to provide coverage for mental illnesses. **Approved.**

S-725-Codey—Mental Health Coverage. Requires health insurers to provide coverage for mental illnesses. **Approved.**

S-726-Codey—Mental Health Coverage. Requires health insurers to provide coverage for mental illnesses. **Approved.**

S-727-Codey—Mental Health Coverage. Requires health insurers to provide coverage for mental illnesses. **Approved.**

S-731-Codey—Child Abuse. Changes the penalty for failure to report child abuse to a crime of the fourth degree. **Disapproved**, there is no evidence that a change in penalty is necessary. It would be better to extend DYFS counseling and hotline coverage and referral.

S-734-Codey—Financial Disclosure. Prohibits physician from referring patients for services in which the physician or his immediate family holds a significant ownership interest unless the patient is advised, in writing, and given the option of a prescription. **Conditional Approval**, pending disclosure is expanded to all providers.

S-738-Codey—Peer Review. Clarifies immunity regarding peer review, expands the committees to

which it applies, and extends immunity to people providing information to such committees in good faith. **Approved.**

S-768-McManimon—Acupuncture. Provides that acupuncturists are eligible for reimbursement under Blue Shield contracts if the service is otherwise covered. **No Action.**

S-784-McManimon—Disability Determinations. Allows psychologists to certify disability. **Active Opposition,** the determination of disability certification is a medical decision.

S-801-Costa—Blood Alcohol Level. Provides that the blood alcohol concentration level of commercial drivers may not exceed .0399. **Approved.**

S-823-Graves—Orthotists and Prosthetists. Provides for the regulation and licensure of orthotists and prosthetists by a separate board which would be under the overall direction of the director of consumer affairs. Orthotic devices must be prescribed by a physician, dentist, or podiatrist. Prosthetic devices must be prescribed by a licensed physician. **Disapproved,** because MSNJ is opposed to the creation of new professional boards unless there is evidence of a need to regulate and license a new profession.

S-906-Hurley—Withholding or Withdrawing of Services in the Event of Terminal Illness. Empowers adults to execute a statutory form of directive to their physicians providing for the withholding or withdrawing of life-sustaining procedures during a terminal illness. The directive would be valid for five years and provides immunity for physicians and other providers complying with such a directive. "Life sustaining" means a modality or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function which would serve only artificially to prolong the moment of death where in the judgment of the attending physician death is imminent whether or not such procedures are utilized. It does not include "the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain." **Action Deferred,** pending further information from MSNJ's Committee on Biomedical Ethics.

S-933-Hurley—Motor Vehicles. Extends implied consent to the taking of blood and urine testing to determine if a driver is "under the influence." Penalties for refusal by repeat violators correspond to penalties for repeat drunken driving. **Approved.**

S-938-Hurley—First Aid Districts. Provides that municipalities can adopt ordinances designating first aid districts. Each of the districts will become separate corporate bodies. All squads within the district are to be under the general supervision of the district authority. **Action Deferred,** pending further information from MSNJ's Committee on Emergency Medical Care.

S-944-Hurley—Hospice Care. Makes hospice care a mandated coverage item under health insurance coverages issued by carriers in New Jersey. **Approved.**

S-1014-Lipman—Medical Residents. Provides that participants in approved graduate education programs will be issued a temporary license not to exceed a six-year period. Approved programs are defined as those accredited by the Accreditation Council for Graduate Medical Education. **Approved.**

S-1018-Lipman—Nursing Practice. Authorizes nurses to practice medicine and to prescribe drugs and devices. **Active Opposition,** nurses are not qualified to make a medical diagnosis nor to prescribe therapeutic medications.

S-1040-Lipman—Health Education. Requires the Department of Education to provide health and wellness programs which are to be incorporated into the curriculum of each school district for grades K-12. **No Action.**

S-1041-Lipman—Health Wellness Insurance Incentives. Requires health insurers to offer wellness incentives. **No Action.**

S-1062-DiFrancesco—Abuse of Elderly, Disabled or Incapacitated Persons. Requires every person who has reasonable cause to believe an elderly or disabled person is the victim of abuse or exploitation to report that information to the commissioner of human services or his designee. **Active Support** (pending further clarification of the bill to existing statute).

S-1114-Cardinale—Monosodium Glutamate. Requires restaurants to notify customers if they use monosodium glutamate in preparation of their food or add it to the food after preparation. Notice would be, in writing, on or attached to the menu. **Approved.**

S-1123-Cardinale—Certificate of Need. Exempts the private practice of medicine from the certificate of need law. **Active Support.**

S-1134-Cardinale—Radiation Protection Commission. Adds two members expert in medical physics and epidemiology to the Radiation Protection Commission. **Approved.**

S-1145-Cardinale—Marriage License Certificate. Requires applicants to be tested for thalassemia, sickle cell anemia, and Tay-Sachs. The physician must notify the applicants of the test results in writing. **Disapproved,** because two far more universal diseases—diabetes and rubella—are not included in the testing and those listed have a limited population susceptibility. The tests themselves would not be medically indicated for a majority of applicants.

S-1146-Cardinale—Noneconomic Damages in Tort. Limits noneconomic damage awards to \$100,000. **Active Support.**

S-1150-Cardinale—Noneconomic Damages in Tort. Places a \$350,000 cap on awards for pain and suffering. The limit shall be revised annually by the Consumer Price Index—U.S.—City Average. **Approved.**

S-1153-Cardinale—Alcoholic Beverages. Requires that alcoholic beverages be labeled to advise of potential harm to fetus when consumed by pregnant women. **Active Support.**

S-1158-Cardinale—Health Lifestyles. Requires health insurers to give financial incentives for health lifestyles under insurance contracts and to offer wellness plans approved by the Commissioner of Insurance and Commissioner of Health. **Conditional Approval,** pending amendment to include periodic health care

examinations.

S-1163-Cardinale—Osteoporosis Study Commission. Creates a 15-member commission to study services to patients with osteoporosis. Five of the members shall be health care professionals. **Disapproved**, osteoporosis is a well-known, researched, and publicized condition—there is no need to create a special legislative commission to conduct studies when comprehensive scientific literature is readily available.

S-1177-Feldman—Privileged Communications. Extends privileged communications to psychiatric social workers and nurses. Also, by implication, it advances the concept that persons other than physicians and psychologists may treat mental health conditions. **Action Deferred**, pending further information from the New Jersey Psychiatric Association.

S-1178-Feldman—Confidentiality of Medical Claims Information. Provides that employers could not review medical claims submitted by employees on claims through the employers' coverage. It assumes that employers discourage claims in order to contain premiums. Applied to Blue Cross. **Approved.**

S-1179-Feldman—Medical Claims Information. Same as S-1178 except it applies to group health insurance. **Approved.**

S-1180-Feldman—Medical Claims Information. Same as S-1178 except it applies to Blue Shield. **Approved.**

S-1188-Feldman—Medical Malpractice. Provides that within 60 days of filing an action against a physician the plaintiff must provide an affidavit from an expert that there has been a negligent deviation from the accepted standards of practice. **Active Support.**

S-1190-Feldman—F frivolous Suits. Authorizes courts to award reasonable attorney fees to a party who has been subjected to a frivolous claim. **Active Support.**

S-1194-Feldman—Withholding or Withdrawing Life Support. Provides that persons 18 years of age or older can execute a directive regarding life-sustaining measures when that person is no longer able to express their own consent and their condition is terminal. **Action Deferred**, pending further information from MSNJ's Committee on Biomedical Ethics.

S-1205-Feldman—Administrative Law. Makes the decision of an administrative law judge final in contested agency actions. **Active Support.**

S-1208-Feldman—Social Work. This bill would establish and license two categories of social workers and would create a Board of Social Work Examiners in the Department of Law and Public Safety whose powers and duties, among others, would be to administer the act, examine, and license candidates for the various categories of social work and promulgate rules and regulations necessary for the effective enforcement of the act.

The two categories of licensed social work would be (1) social work specialists, who would be required to have a doctorate in social work or a master's degree from an accredited school of social work and (2) social workers who would need a baccalaureate degree from an accredited college or university social work or social welfare program.

The bill would "grandfather" in all persons currently in practice, provided they have been in practice in one of the two licensed categories for two of the last five years and apply to be licensed within 180 days from the effective date of this act. **Active Opposition**, because there has been no demonstrative need for licensure of this occupation as a separate and independent profession.

S-1226-Feldman—Malpractice Study. Requires the State Board of Medical Examiners to analyze the data that has been reported to it regarding malpractice and to make findings and recommendations to the legislature. **Approved.**

S-1242-Feldman—Surrogate Parenting. Establishes a commission to study surrogate parenting. **Action Deferred**, pending further information from MSNJ's Committee on Biomedical Ethics.

S-1249-Feldman—Cardiopulmonary Resuscitation (CPR). Requires each local board of education to provide instruction in CPR to all secondary pupils. **No Action.**

S-1252-Contillo—National Health Care. Provides for a nonbinding referendum concerning the enactment of a national health plan. **Active Opposition**, the bill presents a utopian approach and does not consider the negative impact of cost and quality factors. It is misrepresentation in the purest form.

S-1270-Ambrosio—Wrongful Death. Provides for noneconomic damages in wrongful death actions where the decedent was a minor. Those damages are limited to \$100,000. **Disapproved**, this would unwarrantedly increase the cost of all liability insurance in New Jersey.

S-1281-Connors—Administrative Law. Creates a legislative commission to review the rules being effected by state agencies. The commission could not prevent a rule from going into effect. It could recommend corrective action. **No Action.**

S-1300-Connors—Disposal of Human Tissue. Provides that human tissue and fetal tissue shall be disposed of by incineration through a licensed facility approved by the Department of Health. **Approved.**

S-1350-Cowan—Council on Disability. Establishes a council on disabilities consisting of 50 persons. The Council is to function as the primary planning and advisory body in state government on the interests and needs of those with disabilities. A subcouncil on developmental disabilities with 20 members is created within the overall council. **No Action.**

S-1351-Rice—Biochemical Disorders. Requires the Department of Health to provide screening and treatment programs for newborns with biochemical disorders. **Action Deferred**, pending further information from New Jersey Academy of Pediatrics.

S-1446-Zane—Organ Transplants. Establishes a commission on transplants to allocate transplant services for New Jersey residents. Out-of-state programs are not recognized if the service is available at

a New Jersey hospital. **Action Deferred**, pending further information from the New Jersey Chapter of the American College of Surgeons.

S-1474-Zane—Handguns (same as A-594). Provides for the issuance of lifetime handgun purchaser cards. **Disapproved**, this bill unwarrantedly liberalizes current law and exposes the public to injury and death.

S-1481-McNamara—AIDS. Establishes an AIDS advisory council within the Department of Health. The council is to advise the commissioner on policy and priorities for preventing, detecting, and treating AIDS. **Approved.**

S-1491-Gagliano—Physician Assistants. Prohibits the licensing and/or practice of physician assistants. **Active Support.**

S-1516-Dalton—Medical Fee Schedule (No-Fault). Provides that the commissioner of insurance shall promulgate a fee schedule at the 90th percentile. The schedules are to be reviewed biannually. **Disapproved**, there is no evidence that physician services are a significant factor in PIP benefits and auto insurance. This bill will create a potential availability crisis.

S-1543-Pallone—School Health Services. Prohibits school health programs from providing services or counseling relating to pregnancy or abortion. **Conditional Approval**, pending amendment to allow educational and counseling service provisions.

S-1553-Pallone—Ocean Environment. Calls for the Department of Health and the Department of Environmental Protection to undertake a health impact study of chlorinated sewage on New Jersey coastal waters. Appropriates \$1 million for the study. **Approved.**

S-1554-Pallone—Artificial Tanning. Requires the Department of Health to establish safety standards for tanning facilities which shall be enforced through the local boards of health. **Disapproved**, since there is no safe level of ultraviolet rays. A bill banning these tanning parlors should be considered.

S-1612-Orechio—Drug Abuse Treatment. Requires health insurers and HMOs to include coverage for drug abuse treatment as for any other illness. **Approved.**

S-1613-Orechio—Drug Abuse Treatment. Same as S-1612. **Approved.**

S-1614-Orechio—Drug Abuse Treatment. Same as S-1612. **Approved.**

S-1615-Orechio—Drug Abuse Treatment. Same as S-1612. **Approved.**

S-1617-Orechio—Drug Abuse Treatment. Same as S-1612. **Approved.**

S-1649-Orechio—Medicare Assignment. Requires health care licensees to accept Medicare determination of their fees. **Active Opposition**, participation in any health plan is not a valid licensure criteria, there is no evidence that a draconian measure of this nature is necessary since over 70 percent of the physicians accept assignment in a given instance. The bill violates the New Jersey and U.S. Constitutions.

S-1685-Bassano—Mental Health Records. Requires institutions to make available mental health records upon request when the patient is an applicant for a police position or firearm permits. **Disapproved**, unnecessary legislation—this situation can be addressed by a release signed by the prospective employee or firearm purchasers.

S-1702-Bassano—AIDS. Makes AIDS a reportable disease. Grants immunity to physicians who deem it advisable to inform sexual partners of the patient's condition. **Action Deferred**, pending report of MSNJ AIDS Task Force.

S-1705-Bassano—Joint and Several Liability. Eliminates joint and several liability. **Active Support.**

S-1706-Bassano—Collateral Sources. Provides that benefits from collateral sources shall be deducted from awards in personal injury actions. **No Action.**

S-1711-Bassano—Emergency Medical Services. Provides that whenever an emergency ambulance vehicle is in service it must be staffed by at least one EMT. **Approved.**

S-1730-Bassano—Viral Disease Research. Establishes a viral disease research bank through cooperation between the Department of Health and the University of Medicine and Dentistry of New Jersey (UMDNJ). **Action Deferred**, pending further information from UMDNJ, the Department of Health, and the Coriell Institute of Camden.

S-1745-Dorsey—Immunization of School Children. Requires all children attending public or private day care centers, nursery schools, and kindergartens to receive HIB vaccinations. **Conditional Approval**, pending amendments confirming there are several HIB vaccines to administer.

S-1749-Dorsey—State Agencies. Creates a joint committee of the Legislature to effect an agency sunset law (i.e. the agency must justify its existence every five years). **No Action.**

S-1763-Dorsey—Renal Disease. Provides state financial support of private, nonprofit renal disease treatment programs. **Disapproved**, renal disease treatment programs are covered under federal programs.

S-1804-Dorsey—Irradiation of Foods. Requires food processors and public eating places to provide written notice regarding irradiated foods. **Approved.**

S-1816-Dorsey—Irradiation of Foods. Prohibits the distribution and sale of irradiated food. **Disapproved**, there is no scientific evidence that irradiation is harmful.

S-1821-Dorsey—Certificate of Need. Exempts FDA approval self-administered test kits from CON requirements. **Approved.**

S-1828-Dorsey—Campaign Contribution. Limits PACs to contributions of \$2,500 in state Assembly and Senate elections. **Disapproved**, limiting the amount which a PAC could contribute to a legislative candidate would disadvantage the individuals who pool their resources in a PAC.

S-1845-Lesniak—Structured Payments in Tort Actions. Provides for structured payments in civil

actions against health care providers when future damages exceed \$250,000. An annuity contract must be offered to guarantee the future payments. **Active Support.**

S-1891-Ewing—Alcohol and Drug Abuse Council. This bill merges the Division of Alcoholism and the Division of Narcotic and Drug Abuse Control within the Department of Health into a single division administered by a deputy commissioner of health. The division will carry out the over all policy and plans established by the Governor's Council on Alcoholism and Drug Abuse which will coordinate all programs within the state. **No Action.**

S-1938-Pallone—Medical Waste. Requires that all medical waste be incinerated by a licensed center. Manifest records must be maintained by the generators, i.e. doctors, dentists, hospitals, the transporters, and the incinerators. **Action Deferred,** pending further information from MSNJ's Committee on Environmental Health.

S-1963-Rice—HIV Antibody Testing. Requires that at the discretion of the court, persons convicted of prostitution may be required to submit to HIV-antibody testing. **Conditional Approval.**

S-1965-Paterniti—Nursing Home Preadmission Screening. Establishes a screening procedure to prevent inappropriate nursing home admissions. **No Action.**

S-1971-Russo—Repeals No-Fault Law. Repeals no-fault and makes PIP optional. **Action Deferred,** pending further information from MSNJ's Council on Medical Services and the New Jersey Orthopaedic Society.

S-1980-Lesniak—Immunity of Trustees of Nonprofit Corporations. Provides that volunteer trustees of nonprofit corporations may be immunized from paying damages to the corporation or its membership. **Approved.**

S-1984-McManimon—Organ Donations. This bill deletes the requirement in the law that a completed organ donation option certificate be attached to a death certificate in order for the death certificate to be deemed complete. This bill is necessary in order to ensure the prompt handling of the deceased once a death certificate is prepared. **Approved.**

S-1986-Rand—Prescription Benefits for State Employees. Provides that prescription requirements and allowances under the state employees program shall apply equally to local pharmacies and the mail-order program. **Approved.**

S-1995-Ewing—Blood Banks (Immunity). Provides that volunteers providing services to blood banks shall be immune from civil liability unless they have acted in a willful, wanton, or grossly negligent fashion. **Approved.**

SR-6-Costa—DRGs. Requests the commissioner of health to conduct a severity of illness study in the DRG program and to file a report with recommendation to the Legislature. **Approved.**

SR-29-Gagliano—HMO Reimbursement. Requests Congress to study the insufficient reimbursement by Medicare to HMO-New Jersey. **Approved.**

SR-41-Dorsey—Irradiation of Food. Requests Congress to impose a moratorium on food irradiation. **Disapproved,** because there is no scientific evidence that irradiation of foods is harmful.

The Reference Committee noted that a vote of thanks was extended to the chairman, Doctor Irving R. Ratner, and members of the Council on Legislation, and to Mrs. June O'Hare, staff liaison to the Council, for the yeoman's work they are doing.

The Reference Committee recommends that the supplemental report be filed.

HOUSE ACTION: Adopted. The supplemental report was filed.

Council on Legislation

IRVING P. RATNER, MD, CHAIRMAN

(Reference Committee "D")

Current State Legislation

The Council offers this Supplemental Report #2 covering items dealt with since the compilation of its Supplemental Report #1.

Senate

S-1963-Rice—HIV Antibody Testing. Requires that at the discretion of the court, persons convicted of prostitution may be required to submit to HIV-antibody testing. **Action Deferred**, pending report of MSNJ's AIDS Task Force (scheduled for Board action on April 27, 1988).

Assembly

A-13-Kavanaugh—Commercial Surrogate Parenting. Prohibits the payment of money for surrogate parenting purposes. **Action Deferred**, pending further information from MSNJ's Committee on Biomedical Ethics.

A-56-Albohn—Legislation. Limits members of the Legislature to the prime sponsorship of no more than 35 bills. Ten bills may be pre-filed, 10 bills introduced in regular session, 10 bills with at least five cosponsors, and 5 bills with at least 20 percent of the members of the Senate or Assembly or a majority of the sponsor's political party in the given House. **No Action.**

A-73-Villane—Blood Donations. Eliminates age restrictions on blood donors. **Approved.**

A-78-Villane—Infant Mortality. Creates a Commission on Infant Mortality consisting of 15 members (4 legislators, 4 doctors, 4 nurses, and 3 commissioners). **Approved.**

A-88-Villane—Social Work. This bill would establish and license two categories of social workers and would create a Board of Social Work Examiners in the Department of Law and Public Safety whose powers and duties, among others, would be to administer the act, examine, and license candidates for the various categories of social work and promulgate rules and regulations necessary for the effective enforcement of the act. The two categories of licensed social work would be (1) social work specialists, who would be required to have a doctorate in social work or a master's degree from an accredited school of social work and (2) social workers who would need a baccalaureate degree from an accredited college or university social work or social welfare program. The bill would "grandfather" in all persons currently in practice, provided they have been in practice in one of the two licensed categories for two of the last five years and apply to be licensed within 180 days from the effective date of this act. **Active Opposition**, because there has been no demonstrative need for licensure of this occupation as a separate and independent profession.

A-110-Villane—Cancer Research. Provides that a portion of the surtax on cigarettes be dedicated to the cancer research fund. **Approved.**

A-121-Villane—Environment. Requires the state government to study the health effects of chlorinated sewage in coastal waters. **Approved.**

A-124-Villane—Medical Waste. Regulates the disposal of medical waste through a complex system which would require every doctor, dentist, etc. to register with the Department of Health and to use a manifest system which includes the filing of detailed quarterly reports. **Action Deferred**, pending further information from MSNJ's Committee on Environmental Health for report back to the Council on Legislation within 60 days.

A-130-Penn—Motor Vehicle Vision Examinations. Provides that a licensed ophthalmic dispenser may certify successful completion of the required visual examination for an operator's license. **Disapproved**, current law is preferable, at this time. Motorists may feel they are receiving a quality eye examination when, in fact, the examination merely consists of eye chart reading and a peripheral and depth perception test.

A-148-Penn—Psychologists. Permits psychologists to certify disability under the temporary disability benefits law. **Active Opposition**, psychologists do not have the educational background and experience necessary to make disability determinations.

A-163-Rocco—Certificate of Need. Provides that certificate of need shall expire after two years unless financing contracts, and necessary variances are obtained. **Conditional Approval**, pending inclusion of the following amendment—"provided the necessary variances are diligently applied for in a timely fashion."

A-211-Naples—Health Insurance. Requires medical service corporations to notify claimants of possible major medical coverage when claims are not paid in full. **No Action.**

A-212-Naples—Health Insurance. Requires hospital service corporations to notify claimants of possible major medical coverage when claims are not paid in full. **No Action.**

A-213-Naples—Major Medical Insurance. Requires certain commercial group health insurers to

notify claimants of possible major medical coverage when claims are not paid in full. **No Action.**

A-217-Naples—Health Care Services. Bars action to enforce the payment of bills for health care services for 60 days under certain circumstances. **Conditional Approval**, pending deletion of lines 33 through 35 of the statement because it is not consistent with the bill language.

A-222-Naples—School Bus Seat Belts. Requires all new school buses to have seat belts and mandates that students use them. **Approved.**

A-245-Felice—Child Abuse Prevention. Creates a 24-member commission to study the problem of child abuse and to recommend methods of prevention. **Conditional Approval**, pending the inclusion of a pediatrician and a psychiatrist on the commission.

A-250-Felice—Methadone Registry. To establish a central registry of persons enrolled in methadone programs. **Action Deferred**, pending an updated report from MSNJ's Committee on Drug and Alcohol Abuse.

A-253-Felice—Nursing Home Mental Patients. Provides that a patient transferred from a psychiatric facility to a nursing home may be returned to the psychiatric facility if a physician certifies it is unreasonable for the nursing home to retain the patient. **No Action.**

A-261-Felice—Nursing Home Preadmission. Establishes a nursing home preadmission screening program to prevent inappropriate admissions. **No Action.**

A-267-Felice—Pharmacy. Prohibits institutions from operating retail pharmacies within 1,500 feet of their facility. (N.B. This bill conditionally vetoed by the governor at the end of the 1987 Session). **Active Opposition**, this bill is anticonsumer and detrimental to the future efforts of hospitals and physicians to diversify services in order to meet cost-containment goals.

A-271-Felice—Osteoporosis. Establishes a commission (15 members) to compile and analyze data on osteoporosis, develop educational programs, and assist local health agencies in public education. **No Action.**

A-294-Kamin—Emergency Services. Allows certified EMTs to perform cardiac defibrillation with or without the assistance of another EMT. **Action Deferred**, pending further information from MSNJ's Committee on Emergency Medical Care.

A-324-Villane—Ocean Pollution. Appropriates \$1,000,000 to Department of Health for a study on the health impact of ocean pollution. **Approved.**

A-353-Cooper—Withholding or Withdrawing Treatment in Terminal Illness. Allows competent adults to issue a directive that provides they shall not be artificially sustained during a terminal condition. **Action Deferred**, pending further information from MSNJ's Committee on Biomedical Ethics.

A-374-Kalik—Prescription Drugs. Intends to alleviate the inability of certain elderly patients to open their prescription containers that are closed with child-proof caps. Amendment to the bill would require a new box and statement on prescriptions. **Disapproved**, because existing law allows the option requested. There is no need to revise prescription blanks.

A-411-Deverin—Abortions. Would permit hospital governing boards to determine whether or not abortions can be performed in the hospital facilities. **No Action.**

A-420-Deverin—Occupational Therapy. Creates a new class of licensed practitioners who would function independently and would be permitted to perform such services as the design, fabrication, and application of splints, sensorimotor activities, the use of specifically designed crafts, guidance in the selection and use of adaptive equipment, therapeutic activities to enhance functional performance; prevocational evaluation and training, and consultation concerning the adoption of physical environments for the handicapped. The State Board of Medical Examiners will exercise jurisdiction. **Active Opposition**, there is no demonstrated public health need to create a licensed professional in occupational therapy. Currently, physical therapists and nurses are meeting the needs of this legislation.

A-424-Deverin—T.B. Test for Nursing Home Employees. Requires that all current and prospective employees of nursing homes be tested for T.B. **Approved.**

A-430-Deverin—Professional Liability. Allows organizations of professionals to form associations to self-insure professional liability. The entities created would be under special regulatory control of the Insurance Department, but are not to be considered insurance companies. **Disapproved**, because the program would not protect the public by assuring adequate financing of insurance mechanisms. Professional associations should be encouraged to form insurance carriers consistent with the insurance code.

A-435-Deverin—Medicaid. Allows the commissioner of human services to make revisions in the eligibility of the medically needy standards which are consistent with federal law. **Disapproved**, because it would subject the New Jersey poor to the control of federal agencies with no circumstantial security through state government action.

A-438-Deverin—Organ Donor Study. Creates a nine-member study commission to make recommendations on an organized donation program. Seven of the nine members are to be nominated by the New Jersey Hospital Association (NJHA). **Conditional Approval**, pending an amendment that would appoint three members from NJHA, three members from the Medical Society of New Jersey, and one member from the Department of Health to the commission.

A-448-Pelly—Impaired Health Professionals. Directs the boards responsible for licensing certain but not all health professionals to institute impaired professional programs. Professional societies would contract with the respective boards to administer the program. There are no details regarding qualifications of personnel or funding. **Action Deferred**, pending further information from MSNJ's Committee on Physicians' Health.

A-470-Colburn—DRG Study Commission. Creates a commission to study the effects of the DRG

program and the rate-setting system in New Jersey on services provided in acute care hospitals. **Active Support.**

A-472-Colburn—Certificate of Need. Creates an exemption from certificate of need requirements when the hospital and two or more physicians joint venture a project that costs less than \$2 million. **Active Support.**

A-474-Colburn—HMO Contracts. Provides that in the event that an HMO and a general hospital or other health care facility with which the HMO has a contract to provide services to its enrollees, are unable to agree on the terms of a new contract upon the expiration of the current contract, the health care facility and the HMO shall continue to abide by the terms of that contract for a period of four months from the date of expiration of the contract, during which time an enrollee of that HMO who has been receiving services from the health care facility under the terms of the previously existing contract may terminate his enrollment in the HMO and purchase health care benefits from another provider or insurance carrier. **Conditional Approval**, pending an amendment to provide that the same notification be forwarded to physicians as well as patients.

A-479-Colburn—Nursing Services. Provides that the costs associated with nursing services must be specifically identified in hospital budgets and rating formulas. **Active Support.**

A-535-Genova—Blood Donations. Provides that it is a disorderly persons offense to donate blood with knowledge that the donor has a communicable disease. **Action Deferred**, pending further information from the New Jersey Blood Banking Task Force.

A-546-Genova—Immunizations. Provides that students in public colleges must produce a medical history of their immunizations for preventable diseases. **Approved.**

A-547-Genova—Blood Donations. Requires blood banks to accept designated donations. **No Action.**

A-587-Haytaian—Physical Therapy. Prohibits physicians from having an ownership interest in a physical therapy practice or from employing physical therapists. **Active Opposition**, in favor of Senator Codey's Financial Disclosure Bill (S-734).

A-748-Shusted—Dialysis Technicians. Hemodialysis technicians would work under the supervision of physicians. This legislation would establish: 1) guidelines for training and education; 2) guidelines for recognized testing and certification procedures; and 3) guidelines to define the role and responsibilities of the hemodialysis technician. **Action Deferred**, pending further information from the New Jersey Nephrology Society and the New Jersey Renal Physicians Association.

A-789-Shusted—Medicaid Coverage. Requires Medicaid coverage of patterning. **Disapproved**, because patterning has not been scientifically accepted and is both controversial and experimental.

A-791-Shusted—Immunity. Provides that volunteer officers and directors of nonprofit corporations shall be immune from certain types of suits. **Approved.**

A-834-Otlowski—Drug Abuse Treatment. Makes drug abuse treatment an included item under all types of health insurance. **Approved.**

A-835-Otlowski—Drug Abuse Treatment. Same as A-834. **Approved.**

A-836-Otlowski—Drug Abuse Treatment. Same as A-834. **Approved.**

A-837-Otlowski—Drug Abuse Treatment. Same as A-834. **Approved.**

A-838-Otlowski—Drug Abuse Treatment. Same as A-834. **Approved.**

A-865-Otlowski—Mental Health/Involuntary Treatment. Assures persons receiving treatment on an involuntary basis in either a screening service or short-term facility of the same rights as patients who have been involuntarily committed to state or county psychiatric facilities. **Action Deferred**, pending further information from MSNJ's Council on Mental Health.

A-886-Kern—Medical Licensure. Increases the penalties for using false credentials to obtain a license or to represent oneself as licensed. Applies to medicine and chiropractic. **Active Support.**

A-887-Kern—Medical Directives. Establishes a procedure and system for execution of medical directives and medical powers of attorneys. **Action Deferred**, pending further information from MSNJ's Committee on Biomedical Ethics.

A-908-Kern—Wrongful Death. Requires that when a wrongful death settlement is "structured," the court will determine prior to the settlement who will receive and in what proportions. **Approved.**

A-918-Kern—Medical Records. Requires hospitals and physicians to provide patients with copies of their records within 30 days of a request by the patient or their representative. **Approved** (conditions already law and would have no effect).

A-951-Kern—Organ Donation. Establishes a recording system for donation cards in the office of the county clerk and the bureau of vital statistics. Physicians or their designees are to inquire as to whether cards are on file. **Disapproved**, unworkable legislation.

A-952-Kern—Organ Sale. Prohibits the sale or purchase of organs. **Approved.**

A-953-Kern—Informed Consent/Fertility Drugs. Provides for statutory informed consent related to the administration of fertility drugs. **Disapproved**, MSNJ is opposed to interference with the practice of medicine by legislation.

A-954-Kern—In Vitro Fertilization. Sets forth the rights and liabilities of persons who wish to participate in alternative reproductive arrangements. **Action Deferred**, pending further information from MSNJ's Committee on Biomedical Ethics.

A-955-Kern—Artificial Insemination. Statutorily regulates artificial insemination, requires certain forms of consent, data gathering, and recordkeeping. **Disapproved**, mandates the practice of medicine by legislation.

A-956-Kern—Surrogate Motherhood. Provides for the recognition of detailed surrogate parenting

arrangements and contracts. **Action Deferred**, pending further information from MSNJ's Committee on Biomedical Ethics.

A-957-Kern—In Vitro Fertilization. Provides that unless there is a written agreement to the contrary, the female party shall have the right of possession of a frozen embryo conceived through in vitro fertilization. **Action Deferred**, pending further information from MSNJ's Committee on Biomedical Ethics.

A-958-Kern—Sterilization. Requires a physician who is requested to perform a vasectomy, tubal sterilization, or other surgical sexual sterilization procedure to inform the patient of the potential for the operation to fail to result in sterility. Also, requires the physician to inform the patient about procedures for storage of reproductive cells for future use. **Disapproved**, since the intent of the bill is to create a standard of medical practice in New Jersey, it is more appropriate to be acted upon by SBME.

A-960-Kern—Psychotherapy/Immunity. Grants civil immunity to psychotherapists for failure to report potentially violent behavior of patients unless there is a readily identifiable victim. **Approved.**

A-963-Kern—Anatomical Gifts (Anencephalic Infants). Provides a method of organ donation from anencephalic infants. **Action Deferred**, pending further information from MSNJ's Committee on Biomedical Ethics.

A-966-Kern—AIDS. Provides that anyone with AIDS who knows of their infection and commits an act of sexual penetration is guilty of a crime of the third degree. **Conditional Approval**, the bill is legally malconstructed since the legal and medical portion of the bill is in error.

A-976-Kern—Insurance. Requires health insurers to pay for treatment of infertility. **No Action.**

A-979-Kern—Medical Directives for the Terminally Ill. Provides that certain family members may request the attending physician to withhold or withdraw treatments of comatose patients who are terminally ill even though the patient did not execute a written directive. **Action Deferred**, pending further information from MSNJ's Committee on Biomedical Ethics.

A-988-Cooper—Autopsy. Requires county medical examiners to make autopsy reports available to family members within 45 days of request. **Action Deferred**, pending further information from Robert Goode, MD, the medical examiner of the state of New Jersey.

A-1024-Collins—Nursing Salaries. Requires the Hospital Rate-Setting Commission to approve an immediate increase of 2 percent in nursing salaries. Also, requires the commissioner of health to contract with a private agency to conduct salary surveys in neighboring states for comparison to those in New Jersey. **No Action.**

A-1039-Singer—Pertussis Vaccine. Requires the commissioner of health to make available to all health providers and parents a pamphlet on adverse reactions to pertussis immunization. The health care provider must give the pamphlet to the parent before administration of the vaccine and must complete and maintain detailed records. Adverse reactions are to be reported to the manufacturer and the Centers for Disease Control. **Disapproved**, the Department of Health can accomplish this under existing law and regulatory authority.

A-1043-Singer—Abused Elderly. Requires reporting of cases of abuse of the elderly and the disabled; establishes a system of protective custody; exempts as abuse acts of withholding treatment that conflict with the patients' religious beliefs. **Action Deferred**, pending further information from MSNJ's Committee on Biomedical Ethics.

A-1047-Singer—Child Abuse Diagnostic Center. Establishes a child abuse diagnostic center in southern New Jersey. **Disapproved**, because there is general availability of these services and talents at most acute care hospitals in New Jersey—special legislation is not needed.

A-1061-Roma—Certificate of Need. Establishes a study commission to evaluate the CON (Certificate of Need) program. **Approved.**

A-1082-Moran—Medicare (Physician Fee Complaints). Establishes a public blacklist to be compiled by the Division of Aging on those physicians whose fees exceed Medicare allowances. **Active Opposition.** Medicare allowances are about 60 percent of usual fees. Further congressional budget cuts will lower them further. The compiling of a list will mislead patients from realizing that doctors are being paid less than they bill. This type of misinformation should be avoided.

A-1104-Moran—Ocean Pollution Study. Requires the commissioner of health to conduct a three-year study of infections contracted by swimming in state coastal waters. Report forms are to be distributed to physicians who shall return them to the Department of Health. **Approved.**

A-1126-Moran—Prescription Drugs. Prohibits mail-order prescription drugs in the benefits program for public employees. **No Action.**

A-1157-Bryant—Withholding Medical Treatment. Amends Title 26 of the Revised Statutes (health code) and establishes a procedure whereby a document, executed in conformity with the Will Statutes, can be relied upon by physicians to withhold or withdraw artificial life-sustaining treatment. **Action Deferred**, pending further information from MSNJ's Committee on Biomedical Ethics.

A-1166-Bryant—Medical Education. Provides for the chancellor of higher education to contract with Meharry Medical College and School of Dentistry, located in Nashville, Tennessee, to export five to ten medical students and three to five dental students into each Meharry class. Admission will be solely on academic merit. Students shall come from disadvantaged or minority background. **Disapproved**, the purpose of this bill can best be resolved by utilizing educational facilities within the state. (N.B. UMDNJ has a very good minority program.)

A-1237-Rooney—Health Care Providers. Provides for the certification of homemaker-home health aides. **Disapproved**, because MSNJ is opposed to new licensure requirements unless a clear public need is demonstrated.

A-1341-Ogden—School Bus Seat Belts. Requires the Department of Education to reimburse school districts for 90 percent of the costs of installing seat restraints in school buses. **No Action.**

A-1343-Ogden—Mental Health Benefits. Requires health insurers and HMOs to require specified amounts of mental health benefits as mandated coverage. **Approved.**

A-1344-Ogden—Mental Health Benefits. Same as A-1343. **Approved.**

A-1345-Ogden—Mental Health Benefits. Same as A-1343. **Approved.**

A-1346-Ogden—Mental Health Benefits. Same as A-1343. **Approved.**

A-1347-Ogden—Mental Health Benefits. Same as A-1343. **Approved.**

A-1348-Ogden—Mental Health Benefits. Same as A-1343. **Approved.**

A-1413-Randall—Political Contributions. Limits PAC contributions to \$2,500 per calendar year. **Disapproved,** limiting the amount which a PAC could contribute to a legislative candidate would disadvantage the individuals who pool their resources in a PAC.

A-1425-Kline—Marriage Licenses. Requires applicants for a marriage license to undergo HLTV-III testing. Physicians are to notify applicants of the test results, in writing. Positive results must be reported to the Department of Health. **Disapproved,** mandatory HIV testing is not cost effective and there is a high incidence of false positives.

A-1428-Kline—HIV Testing. Requires persons who are charged with certain sexual crimes to be tested for HIV sensitivity. **Approved.**

A-1455-Kline—Insurance. Prohibits denial of health insurance because a person is HIV positive or has AIDS. **No Action.**

A-1456-Kline—Organ Transplants. Prohibits organ transplants unless the tissues are HIV negative. **Disapproved,** unnecessary legislation.

A-1457-Kline—AIDS (Funeral Directors). Requires doctors, nurses, or the medical examiner to notify the funeral director in writing if the decedent had or was suspected of suffering from a communicable disease. **No Action.**

A-1460-Kline—AIDS Reporting. Requires that patients with positive HLTV-III be reported to the Department of Health within 72 hours. The Department of Health shall institute contact tracing. All information is to be confidential. **No Action.**

A-1464-Kline—AIDS Confidentiality. Makes it a crime of the fourth degree for state employees to make an unauthorized disclosure of AIDS reports which have been submitted to the Department of Health. **No Action.**

A-1468-Kline—Medical Transport. Requires all medical transport systems to accept patients with AIDS. **Approved.**

A-1532-Doria—Chiropractic. Creates a licensing board for chiropractic. Transfers all functions and responsibilities of the State Board of Medical Examiners regarding chiropractic to the new board. Removes the place for a chiropractor from the medical board. **Active Opposition,** because there is no demonstrative need for this legislation. Chiropractors are adequately supervised under the jurisdiction of the New Jersey State Board of Medical Examiners.

A-1538-Doria—Professional Liability. Requires that all closed professional liability claims be reported to the Department of Insurance. **Active Opposition,** closed claims with payments already are reportable.

A-1542-Doria—Hospital Practice By Dentists. Permits dentists who have had their credentials approved to practice in hospitals. **Active Opposition,** this bill would allow dentists to make medical diagnosis and medical decisions for which they have not been properly educated.

A-1544-Doria—HMO Free Choice of Provider. Allows HMO beneficiaries free choice of provider. Limits HMO liability to its established fee schedule. In the case of capitation or salaried plans, the Medicaid fee schedule would be used. **Active Support.**

A-1591-Bennett—Licensing of Health Professionals. Requires statutory authorization for the licensure or certification of health care practitioners. **Active Support.**

A-1600-Kelly—Nurse Practitioners. Allows nurses who practice in collaboration with physicians to prescribe medications in accordance with protocols submitted to and approved by the State Board of Nursing. **Active Opposition,** nurses are not qualified to make medical diagnosis nor to prescribe therapeutic medications.

A-1673-Brown—Infant Mortality. Creates an infant mortality prevention program in the Department of Health to provide obstetrical and prenatal services to women with high-risk pregnancies. Also, provides postpartum followup services. Seven hospitals are designated by statute with three to be added by the commissioners. Two million dollars is appropriated. **Approved.**

A-1678-Brown—Seat Belts. Requires seat belt use by all persons under 18 regardless of where in the vehicle they are seated. **No Action.**

A-1700-Martin—Registry for Head Injuries. Requires physicians and hospitals to report patients with head injuries to the Department of Health. **Disapproved,** unworkable legislation, because the number of cases would be infinite due to the various types of injuries.

A-2305-Karcher—Mandatory Medicare Assignment. Requires health practitioners to accept Medicare assignments. **Active Opposition,** participation in any health plan is not a valid licensure criteria, there is no evidence that a draconian measure of this nature is necessary since over 70 percent of physicians claims are paid on assignment. The bill violates the New Jersey and United States Constitution.

AR-29-Farragher—Medicare Fees. Requests Congress to raise fees to doctors participating in Medicare. **Active Support.**

At its meeting on Wednesday, April 27, 1988, the Board of Trustees approved all the positions recommended by the Council on Legislation on Supplemental Report #2, with the exception of the following which were amended to read as follows:

a. **S-1963-Rice—HIV Antibody Testing.** This bill requires that at the discretion of the court, persons convicted of prostitution may be required to submit to HIV-antibody testing. The Council had taken a position of action deferred, pending report of MSNJ's Task Force on AIDS. The Board voted to change the position on S-1963 to **Conditional Approval**, provided the bill is amended to require HIV-antibody testing for individuals arrested for prostitution or other sexual crimes.

b. **A-267-Felice—Pharmacy.** This bill prohibits institutions from operating retail pharmacies within 1,500 feet of their facility. (N.B. This bill conditionally vetoed by the governor at the end of the 1987 session.) The Council had taken a position of active opposition, as this bill is anticonsumer and detrimental to the future efforts of hospitals and physicians to diversify services in order to meet cost-containment goals. The Board changed the position on A-267 to **Action Deferred**, pending discussion with the New Jersey Hospital Association.

c. **A-271-Felice—Osteoporosis.** This bill establishes a commission (15 members) to compile and analyze data on osteoporosis, develop educational programs, and assist local health agencies in public education. The Council had taken a position of no action. The Board changed the position on A-271 to **Disapproved**, because osteoporosis is a well-known, researched, and publicized condition, and there is no need to create a special legislative commission to conduct studies when comprehensive, scientific literature is readily available (same as S-1163).

d. **A-472-Colburn—Certificate of Need.** This bill creates an exemption from certificate of need requirements when the hospital and two or more physicians joint venture a project that costs less than \$2 million. The Council had taken a position of active support. The Board changed the position on A-472 to **Action Deferred**, pending discussion with the New Jersey Hospital Association.

The Reference Committee noted that a vote of thanks was extended to the chairman, Doctor Irving P. Ratner, and members of the Council on Legislation, and to Mrs. June O'Hare, staff liaison to the Council, for the yeoman's work they are doing.

The Reference Committee recommends that the supplemental report be filed.

HOUSE ACTION: Adopted. The supplemental report was filed.

Council on Public Relations

FRANK PRIMICH, MD, CHAIRMAN

(Reference Committee "D")

The Council on Public Relations maintains the continuity of our coordinated public relations program in reaching the public, the membership, and the media. The Council studied a variety of projects and instituted those falling within the mandates of the House of Delegates, the Board of Trustees, and the available resources.

1. Resolutions from the House of Delegates—1987 Annual Meeting.

A. Resolution #14—Free Choice of Physician.

Resolved, that the Medical Society of New Jersey establish a program by which the component societies will be assisted in educating the public as to the advantages of free choice of physician by making physician members available to speak to any individual or group that has been solicited by a representative of a prepaid plan that uses participating physician panels.

The Council discussed the recommendation included in Resolution #14 proposing that physician members be made available to promote advantages of free choice of medical service to individuals or groups who have been solicited by representatives of a prepaid health care plan that uses physician advocate panels. The most support for HMO-type delivery of health care comes from corporation and union groups. They indicate health care delivery is the single greatest cost in their participant benefit program. They indicate contracts with HMOs give them control of cost and delivery that cannot be obtained otherwise.

The development and implementation of a competitive "free choice" program would have to be competitive to the many options offered by the HMOs and comparatively priced. There apparently is no way MSNJ could determine what individuals or groups were being solicited privately by HMOs unless it was volunteered. A competitive "free choice" program would need to be administered and audited for quality and delivery of care. The largest single alternative to "free choice" is self-insured corporation programs and they are increasing according to a Blue Cross/Blue Shield survey. An attack on alternative health care programs that did not offer supporting evidence of a "free choice" delivery system that was equal or superior to the competition would present the possibility of legal action.

There are problems involved in offering a specific promotion elaborating the merits of a singular type of health care delivery when 40 percent of MSNJ's membership are involved with HMOs and other similar types of practice.

We have considerable input from the public listing their complaints regarding some of the alternate health care systems. Rather than get into negative finger pointing controversy via the media, we will continue to encourage the public to investigate all the options. We repeatedly suggest they exercise the privilege of discussing their health care concerns with their doctors.

The new ad—"Health Care Options. They're Enough To Make You Dizzy"—was published in daily newspapers on August 27, 1987. The ad strongly suggests careful evaluation of alternative health care options before accepting them. The Council on Public Relations is of the opinion this ad addressed the free practice of medicine without offending membership or promoting legal problems. This type of promotion was expanded to continue to address "free choice of physician."

B. Resolution #20—MSNJ Public Relations Activities.

Resolved, that the Medical Society of New Jersey make an all-out public relations effort to include, but not be limited to, a regular, planned series of: articles and press releases; and appearances on talk shows and public speaking engagements, as well as Society-sponsored and produced shows on cable TV, designed to articulate the Society's position in regard to professional liability and governmental intrusion into the practice of medicine.

The Council is planning implementation of this Resolution, excluding electronic media programs because they are not within the fiscal capacity of the Medical Society of New Jersey.

C. *Substitute Resolution #24—Mandatory Assessment for Patient Education.* The third resolved of Substitute Resolution #24 was, "that the Board of Trustees explore opportunities for cooperation with neighboring state societies (Delaware, New York, Pennsylvania, and Connecticut) in the sponsorship of medical programs."

On June 1, 1987, letters were sent to the state medical societies of Delaware, New York, Pennsylvania, and Connecticut, asking for comments on the proposal. The response of all four medical societies was unfavorable, and no further action was contemplated.

2. Continuing Projects.

A. Publication and distribution of: (1) *Membership Newsletter*; and (2) *Monthly PR releases*: Health Care Package; Average Hospital Stay; No To Mandatory Medicare; Enough To Make You Dizzy-Options; Don't Let The Genie Out Of The Bottle; 10 Ways To Cut Medical Expenses; Don't Stop Depending On Your Doctor; Is Your Doctor Keeping Up With Today's Medicine? 75 Percent Of Lawsuits Against Doctors Are Thrown Out Of Court; HMOs—How It Affects Your Choice; HMO Solicitations; Free Choice Of Doctors; Drunken Driving; Truth About Medicare; Which Medical Insurance Plan Is For You; Have A Complaint? Will There Be A Doctor Available? There were multiple media releases in the newspapers across the state and in *Newsweek* and *Time* magazines addressing alternate health care options.

B. Preparation and publication of special news releases and publicity as required from time to time in furtherance of the Society's business interest and activities, including: 1) Annual Meeting; 2) selected official programs and activities; and 3) professional liability—through newspaper articles explaining MSNJ's position on professional liability, DRGs, and Medicare.

C. The Golden Merit Award ceremony continues to be an important function at which our senior physicians, who have held the degree of Doctor of Medicine for 50 years, receive special recognition. In 1987, 117 physicians were so recognized, making a total of 2,027 since the awards began in 1957. The recipients and their families receive undivided attention from the state and county leaders prior to the formal awards ceremonies and during the reception that follows.

D. Encouragement of the continuance or establishment of orientation programs for new members by the component societies.

E. Placement services in *NEW JERSEY MEDICINE*.

F. Encouragement of medical television programs of informational value to the public—Channel 9-13 (cable) plus commercial stations in New York and Philadelphia, plus political action program support (NJPT).

G. Coordinate efforts of the Council on Public Relations with the Committee on Drug and Alcohol Abuse for future MSNJ involvement in drug abuse education and prevention.

3. **Newspapers.** During the past year, we publicized health topics such as the cost of medical care, choosing your own doctor, professional liability, drunken driving, driving while drug impaired, health care options, mandatory Medicare assignment, Medicare premium increase, depending on your doctor, and keeping up with modern medicine.

4. **Magazines.** *Newsweek* and *Time*—DRG Statistics; Don't Let the Genie Out of the Bottle; Is Your Doctor Keeping Up? 75 Percent Of Lawsuits Against Doctors Are Thrown Out Of Court.

5. **Television.** In 1987, public service announcements aired out of New York and Philadelphia and reached over three million viewers. This is our most effective method of reaching the population of New Jersey. Cooperation from the television stations and radio stations running our material continued to be excellent. The air time is provided free as a public service on subjects such as AIDS, Medicare, DRGs, Health Care Options, answers to the SCI Report, cutting your medical expenses, cocaine abuse, and seeing your doctor.

6. **Special Programming.** Development of new TV media programming on DRGs, Medicare, Medicaid, AIDS, and legislative activities.

Participation on Governor's Committee on Highway Safety.

Participation on Governor's Committee on Child Abuse.

Support of Eye Health Screening Promotion.

The Council on Public Relations in cooperation with the Committee on Drug and Alcohol Abuse continues to make public service promotions on the hazards of the misuse of drugs.

Talk Shows. Considerable effort was extended in exploring electronic media outlets in Philadelphia and New York to determine interest in programming talk shows on DRGs, AIDS,

doctor population, Medicare, HMOs, and PROs. There was not much interest in donating air time by the station programmers for subjects that have frequented the media of late. The cost of buying time combined with the lack of proper funding prevents any further effort for talk shows. The difficulty in arranging busy physician speakers for committed air time further complicated this effort. The exception being Dr. Primich's appearances on TV Channel 9 and a Philadelphia radio station.

PR Support of Legislative Efforts by Katz Martin Brill & Company. The Society's battle to defeat the mandatory Medicare assignment bill (A-2511) gave the Council on Public Relations one of its greatest-ever challenges as well as its biggest victory in 1987. Sponsoring the election returns on New Jersey Network on the evening of November 3. Sponsorship of the program provided us seven spots, consisting of the Society seal, name and voice-over that the program was being sponsored by the Medical Society of New Jersey. Preparing and generating media interest in a press release announcing the Society's retaining former U.S. Judge Herbert J. Stern as special counsel in response to the SCI report on impaired and incompetent physicians; coordinating campaigns against three major anti-medicine bills: A-2647, which would prohibit physicians from employing physical therapists or having a financial interest in any facility (such as a cardiac rehab center) which offers physical therapy, S-2261, which would permit optometrists to diagnose and treat eye disease as if they were physicians, and S-2721, which would authorize nurses to diagnose disease and prescribe drugs. All three bills were stopped.

Appreciation was expressed for the efforts of Doctor Frank J. Primich, chairman, and the members of the Council on Public Relations during the past year. It was the feeling of the Reference Committee that the Council on Public Relations should do more to promote the senior citizens program adopted by the 1987 House of Delegates (Resolution #27).

The Reference Committee recommends that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

Resolution #1

Introduced by: Essex County Medical Society
Subject: Freedom of Choice for Residency Program Directors
Referred to: Reference Committee "D"

Whereas, graduate medical education programs in the various specialties are reviewed and accredited by residency review committees of the respective specialties; and

Whereas, the program directors of these residency programs have the clearest opportunity to assess the qualifications of applicants to these programs; and

Whereas, this assessment includes review of written application and personal interviews; and

Whereas, the particular local needs of the program are best known by the respective program directors; now therefore be it

Resolved, that the Medical Society of New Jersey adopt the policy that: a) Candidates for residency programs should be selected solely on the basis of the qualification and merit as determined by local residency program directors and their selection committees. b) No *quota-restriction* should be imposed on these program directors by any governmental agency with respect to funding of programs based upon composition of American or foreign-trained physicians so long as these programs are approved by their respective residency review committees; and be it further

Resolved, that a similar resolution be sent to the American Medical Association for adoption at its annual meeting in June 1988.

The Reference Committee recommends that Resolution #1 be adopted with one editorial change (noted in *italics*).

HOUSE ACTION: Adopted. Resolution #1 was adopted with the editorial change.

Resolution #13

Introduced by: Union County Medical Society
Subject: Foreign Medical Graduates
Referred to: Reference Committee "D"

Whereas, medical graduates of foreign medical schools have passed the required examinations and completed residency training programs and are licensed to practice medicine in the United States of America. Many of them are certified by the specialty boards; and

Whereas, 20 percent of the AMA membership is composed of foreign medical graduates, who are loyal and support the AMA; and

Whereas, many of them are willing to provide a high level of care in underserved areas; and

Whereas, the unity of the AMA is extremely important to all its members; now therefore be it

Resolved, that the Medical Society of New Jersey request the AMA to establish a policy to oppose discrimination in any form or manner based on sex, ethnic background, country of origin, or location of medical school; and be it further

Resolved, that the Medical Society of New Jersey request the AMA to strive to remove discrimination in residency training programs, admission to examinations, medical staff, academic appointments, and professional society memberships; and be it further

Resolved, that the Medical Society of New Jersey request the AMA to join with its state and local medical and specialty medical societies to remove discrimination in licensure requirements based on geographical location of the medical school.

All comments made at the meeting were in favor of the Resolution.

The Reference Committee recommends that Resolution #13 be adopted.

HOUSE ACTION: Adopted. Resolution #13 was adopted.

Resolution #16

Introduced by: Philip Brien, MD, Delegate Essex County
Subject: Equality of Testing Foreign Medical Graduates
Referred to: Reference Committee "D"

Whereas, foreign medical students and graduates of foreign medical schools now are required to take a separate examination in order to qualify for graduate medical education in the United States; and

Whereas, graduates of American medical schools take a different examination than that given foreign medical graduates; and

Whereas, all applicants for graduate medical education and licensure should be held to the same standard as measured by a single examination; and

Whereas, the AMA Council on Medical Education, at the 1987 Annual Meeting, recommended that "the AMA urge the Educational Commission for Foreign Medical Graduates to consult with the National Board of Medical Examiners concerning the possible use of Parts I and II of the National Board Examination for ECFMG Certification"; and

Whereas, there has been no noticeable movement in achieving the goal of a single, unified examination for both American and foreign medical graduates; and

Whereas, the Medical Society of New Jersey repeatedly has addressed the American Medical Association on this issue; now therefore be it

Resolved, that the Medical Society of New Jersey strongly urge the American Medical Association, in accordance with the spirit of Recommendation V of the report of the Council on Medical Education which was adopted by the House of Delegates in June 1987, to call upon the National Board of Medical Examiners and the Educational Commission for Foreign Medical Graduates to implement promptly the administration of a single test to all applicants for graduate medical education in the United States; ~~and be it further~~

~~**Resolved**, that the American Medical Association call upon the United States Congress to amend the law so as to require that all applicants for graduate medical education be administered the National Board of Medical Examiners' examination Parts I, II, and III, without regard to the source of the individual's educational background, so long as it is from a school approved by the country of its location.~~

All comments made at the meeting were in favor of the Resolution.

The Reference Committee recommends that Resolution #16 be adopted.

HOUSE ACTION: Not adopted. Resolution #16 was adopted as amended by the House.

Resolution #17

Introduction: Carlo Porcaro, MD, Delegate Essex County
Subject: Endorse Formation of a Section on Foreign Medical Graduates Within the Structure of the AMA
Referred to: Reference Committee "D"

Whereas, foreign medical graduates have been subjected to deliberate discrimination with regard to opportunities in residency training; and

Whereas, foreign medical graduates are faced with both intentional and unintentional discrimination in obtaining practice opportunities; and

Whereas, the United States Senate has continued the assault on funding for foreign medical graduates in graduate medical education; and

Whereas, foreign medical graduates feeling a strong allegiance to the American Medical Association and comprising more than one-fourth of its membership, feel that issues relating to their unique position should be given a more thorough hearing within the American Medical Association; and

Whereas, Report MM of the American Medical Association Board of Trustees (A-87) recommended the establishment of such section; now therefore be it

Resolved, that the Medical Society of New Jersey support the formation of a section on foreign medical graduates within the structure of the American Medical Association; and be it further

Resolved, that the New Jersey delegation to the American Medical Association introduce a similar resolution at the 1988 AMA Annual Meeting.

There was much discussion in favor of this Resolution. Mention was made that this Resolution was considered at the AMA last year and was defeated, based on comments of a number of foreign medical graduates who felt that they had integrated into the mainstream of medicine and that a section on foreign medical graduates would be counterproductive. On the other hand, in the discussion of this Resolution, a number of foreign medical graduates felt that they were being discriminated against by the AMA and that such a section would be beneficial in answering their needs. The Reference Committee, therefore, felt that if the foreign medical graduates themselves perceive the need for such a section, the creation of a section with the AMA should be supported.

The Reference Committee recommends that Resolution #17 be adopted.

HOUSE ACTION: Not adopted. Resolution #17 was rejected.

1988 HOUSE OF DELEGATES

**Medical Society of New Jersey
222nd Annual Meeting
April 28 - May 1, 1988**

REFERENCE COMMITTEE "E"

REPORTS

**Council on Mental Health
Council on Public Health
Board of Trustees' Item: Task Force on AIDS
Resolutions #14, #15**

MEMBERS

**Leticia V. deCastro, MD, Chairman
Anthony J. DiCroce, MD
William W. Fithian, MD
Maceo M. Howard, MD
Stephen R. Shapiro, MD
Om P. Sawhney, MD, Alternate Member**

Council on Mental Health

CHURCHILL L. BLAKEY, MD, CHAIRMAN

(Reference Committee "E")

1. **Resolution on Psychiatry.** The Council on Mental Health, after careful deliberations, agreed that the Society should recommend that any patient with a mental illness in need of treatment should be seen for assessment and formulation of treatment recommendations prior to referral to a nonmedical mental health professional. Mental illness is defined as those disorders listed in the diagnostic and statistical manual of the American Psychiatric Association. It must be assured that both biological and social factors in the causation of a mental disorder are identified and adequately addressed in the treatment plan.

As a result, the Council on Mental Health submitted the following Resolution which was approved by the Board of Trustees at its meeting on December 20, 1987:

Whereas, the Medical Society of New Jersey seek to ensure continued high-quality medical care of all patients; now therefore be it

Resolved, that the Medical Society of New Jersey encourage the practice of consultation with a psychiatrist for evaluation, assessment, and recommendations before referring to nonmedical mental health professionals in the course of treating a patient with a mental illness.

2. **Mental Health Services Booklet.** The Council on Mental Health met once, on October 28, 1987, and reorganized. At this time the Council concluded that an update of the Mental Health Services Booklet (statewide directory is from 1974) is worthy but unfundable unless alternative sponsorship was found (\$6,000 for printing and distribution).

3. **New Jersey State Department of Health—Child and Adolescent Acute Psychiatric Bed Standards.** The Council set in motion commentary (with the New Jersey Psychiatric Association) on the New Jersey State Department of Health Certificate of Need: Psychiatric Inpatient Beds—Child and Adolescent Acute Psychiatric Bed Standards. New Jersey Psychiatric Association comments were received by the Department of Health.

The Reference Committee recommends that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

Council on Public Health

CHARLES J. MOLONEY, MD, CHAIRMAN

(Reference Committee "E")

1. **Educational Seminar on Counseling Related to HIV Testing.** The Council on Public Health considered the need for guidelines and training in counseling of HIV positive patients. It was agreed that not all physicians are equipped to counsel such patients. However, though many refer their patients to other entities for counseling, some physicians wish to take an active part in this phase of treatment and would be interested in education in this area.

As a result of these deliberations, the Council recommended that the Medical Society of New Jersey sponsor an educational seminar for physicians on counseling related to HIV testing. The Board of Trustees approved this recommendation at its meeting on December 20, 1987, and a seminar is scheduled for March 16, 1988, entitled "AIDS, The Physician, and The Patient."

2. **Multidisciplinary Consultation in Cancer Treatment Planning.** The Committee on Cancer Control reviewed a letter from a radiation oncologist asking for endorsement of the concept of multidisciplinary consultation treatment planning for cancer patients.

The Committee on Cancer Control has gone on record as encouraging all hospitals in New Jersey to participate in the approval program of the Commission on Cancer of the American College of Surgeons, thereby voluntarily submitting themselves to review and, if necessary, upgrading their multidisciplinary approach to cancer. Their goal is to bring every general medical and surgical hospital in New Jersey into the approval process of the Commission on Cancer.

For these reasons the Committee on Cancer Control submitted the following recommendations which were approved by the Board of Trustees at its meeting on December 20, 1987:

- a. That the Medical Society of New Jersey endorse the concept of multidisciplinary consultation by diverse medical specialties such as surgery, medicine, radiation, therapy, and pathology in the evaluation and management of cancer patients.
- b. That the Medical Society of New Jersey endorse the American College of Surgeons approval program, including the multidisciplinary tumor board/conference and the hospital tumor registry.
- c. That all hospitals be encouraged to participate in the program and seek full approval.

3. **Ocean Pollution Study.** The Committee on Environmental Health has played an active role as intermediary between the New Jersey Department of Health and the organization Save Our Shores in formulating and implementing a study of ocean pollution. A preliminary study was done this year with a final formal study to be conducted during the summer of 1988.

4. **Eye Health Screening Program.** The Council's Committee on Conservation of Vision is responsible for the Eye Health Screening Program, sponsored by the Medical Society of New Jersey, which has been held annually for 30 years. In 1987, it was held the week of October 5, with 6,944 persons being screened. Out of that total, 413 glaucoma suspects were found.

The Reference Committee recommends that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

Board of Trustees' Item

TASK FORCE ON AIDS

HARRY M. CARNES, MD, CHAIRMAN

(Reference Committee "E")

The Task Force on AIDS was appointed in December and charged with recommending AIDS policy and providing AIDS education for New Jersey physicians.

Meetings of the Task Force were held on January 27, February 24, and March 23. The Board of Trustees considered the recommendations offered by the Task Force on AIDS on April 10, and took the following actions:

Social/Ethical Issues

(a) *Refusal To Treat.* The Task Force recognizes the right of the physicians to determine which patients he/she will serve. The Task Force believes that a categorical refusal to treat patients with AIDS is morally and ethically unacceptable.

(b) *Confidential Versus Anonymous.* The Task Force recognizes that all HIV positive test results be kept confidential (patient's name with a number) as opposed to being kept anonymous (John Doe and a number).

(c) *Distribution of Free Needles to Addicts.* The Task Force recommends that free needles not be distributed to addicts as a means of suppressing the AIDS virus, but supports an increase of funding for drug treatment centers thereby reducing the present waiting time to get into a program.

(d) *Education.* The Task Force recommends mandatory AIDS education programs be established in the New Jersey public school system.

Items (a) through (d) were approved by the Board of Trustees.

HIV Testing

(a) *HIV Testing.* The Task Force recommends that HIV testing be performed whenever it is clinically indicated. Positive test results should never be used as a means of discrimination in the care and treatment of individuals. Testing for AIDS should include documentation as to the need for the test, confidentiality, and pre- and post-counseling.

(b) *Hospital Patients.* The Task Force recommends that all patients in high-risk groups be tested, as well as any other patient when it is clinically indicated, e.g., organ donors. HIV testing should be utilized as a diagnostic procedure, and not as a method to screen individuals for procedures. Hospitals should establish a policy to assure HIV testing does not result in discrimination against those infected.

(c) *HIV Office Testing.* The Task Force recommends that HIV testing be performed through a licensed reference laboratory, coupled with patient counseling under the auspices of a physician.

(d) *Premarital Testing.* Because mandatory premarital testing is not cost-effective and would result in a high incidence of false positives, the Task Force recommends physicians encourage and assist in the decision of those in high-risk groups to be voluntarily tested.

(e) *Life Insurance.* The Task Force does not recommend mandatory or compulsory testing of those seeking life insurance, but respects the rights of insurance providers to ask if an individual is HIV positive. However, individuals should be informed if they are to be tested for HIV. If the results prove positive, the individual's physician of record must be notified for counseling of the individual.

(f) *HIV Positive Health Care Personnel.* The Task Force recommends that each hospital establish its own policy and mechanism to determine the scope and performance of health care personnel who are HIV positive.

(g) *Pregnancy.* The Task Force recommends routine testing, with informed consent, of all pregnant women who are in high-risk groups and/or those residing in high-risk geographic areas. If the patient refuses, a waiver should be obtained confirming refusal.

(h) *United States Citizens Who Have Lived or Traveled Abroad.* The Task Force recommends testing of any citizen who has lived or traveled abroad to high-risk geographic areas

for three months or more, and that the test be repeated three months after the initial test.

(i) *State and County Prisoners.* The Task Force recommends that all new prisoners be tested, with a repeat test after three months, and further, that all HIV positive prisoners be separated from the general prison population.

(j) *Sexual Crimes and Prostitution.* The Task Force recommends that mandatory testing be implemented for anyone arrested for a sexual crime or prostitution.

(k) *Testing in Drug Clinics.* The Task Force recommends mandatory testing of individuals in drug rehabilitation programs.

Items (a) through (k) were approved by the Board of Trustees.

Proposed Legislation

Note: The Task Force recommends that all proposed legislation use common terminology, i.e. HIV antibody testing rather than antibody, and HIV positive rather than AIDS.

A-1425. Requires applicants for marriage licenses be tested for antibodies to HIV, the causative agent of AIDS. The Task Force recommends disapproval of A-1425, because HIV testing as a requirement for a marriage license is not cost effective and there is a high incidence of false positives. Consideration of A-1425 was postponed until the April 27, 1988, meeting of the Board.

A-1457. Requires funeral directors to be notified of death related to AIDS or any communicable disease. The Task Force recommends disapproval of A-1457, because this legislation imposes an inordinate burden on the physician. If funeral directors follow the universal precautions outlined in the Centers for Disease Control guidelines regarding patient's blood and body fluids, legislation becomes unnecessary. The Board voted to take no action.

A-1460. Report all cases of AIDS or positive tests for AIDS antibody to the Department of Health for followup tracking. The Task Force supports the concept, but recommends no action on A-1460, since the Department of Health has a program in process and is gathering data to determine whether tracking is successful with HIV patients. The Board approved the position on A-1460 as recommended by the Task Force on AIDS.

A-1464. Unauthorized disclosure of certain information pertaining to AIDS as a crime of the fourth degree. The Task Force recommends no action on A-1464, because there are adequate laws and regulations which sufficiently address unauthorized disclosure. The Board approved the position on A-1464 as recommended by the Task Force on AIDS.

A-2524. Reporting seropositive test results to spouse made mandatory. The Task Force favors the concept, but recommends *conditional approval* of A-2524 if amended to include enlargement of spouse category to nonspousal sexual partner, and reporting of the seropositive individuals to the Department of Health who, in turn, would contact the spouse/nonspousal partner. The bill should contain immunity for the physician from civil liability. The Board approved the position on A-2524 as recommended by the Task Force on AIDS.

S-1481. Establishes AIDS Advisory Council. The Task Force recommends approval of S-1481, with consideration to be given for representation also being based on geographic regions of the state. The Board approved the position on S-1481 as recommended by the Task Force on AIDS.

The Reference Committee suggested that the Task Force consider deleting the sentence in the paragraph under (a) HIV Testing, "Testing for AIDS should include documentation as to the need for the test, confidentiality, and pre- and post-counseling," because (1) determination of need is ambiguous; (2) "confidentiality" may create many legal problems and is almost impossible to implement; and (3) there is not clarification as to who does the pre- and post-counseling. The Reference Committee discussed A-1457. The bill requires funeral directors to be notified of death related to AIDS or any communicable disease. The Reference Committee supports the Board's position of no action.

The Reference Committee recommends that the report be filed.

HOUSE ACTION. Not adopted. The report was referred back to the Board of Trustees for further study.

Resolution #14

Introduced by: Burlington County Medical Society
Subject: Emergency Telephone Number—Enhanced #911
Referred to: Reference Committee "E"

Whereas, New Jersey presently has no universal emergency telephone number; and
Whereas, the Enhanced 911 Emergency Number is established and effective in other states;
and

Whereas, the establishment of a universal emergency telephone number in New Jersey is needed and overdue; now therefore be it

Resolved, that the Medical Society of New Jersey seek passage of regulations or legislation to establish the Enhanced 911 Emergency Number system in New Jersey.

The Reference Committee recommends that Resolution #14 be adopted as it is a reaffirmation of existing Society policy.

HOUSE ACTION: Adopted. Resolution #14 was adopted.

Resolution #15

Introduced by: C. Clayton Griffin, MD, and Bartholomew J. Tortella, MTS, MD,
Delegates, Essex County
Subject: Emergency Medical Services System for New Jersey
Referred to: Reference Committee "E"

Whereas, emergency medical services systems, both volunteer and paid professional units, provide valuable medical care in the field and transport to medical facilities; and

Whereas, this sophisticated system largely is unknown to the public, and even some members of the medical community; and

Whereas, there exists a clear need to inform the lay public and the medical community in New Jersey of the emergency medical services system and its role in caring for patients; and

Whereas, many volunteer first-aid squads are unable to provide coverage to their communities 24 hours a day because of a lack of volunteer squad members; and

Whereas, currently there are no existing systems to coordinate emergency medical services on the county, regional, or state level; now therefore be it

Resolved, that the Medical Society of New Jersey support the development of a coordinated emergency medical services system in New Jersey to assist in education, administration, and development of emergency medical services; and be it further

Resolved, that the Medical Society of New Jersey support the recommendations of the Governor's Council on Emergency Medical Services.

The Reference Committee felt that Resolution #15 required further study because the word support in the first resolved was not clearly defined, and the final report of the Governor's Council on Emergency Medical Services has not been released.

The Reference Committee recommends that Resolution #15 be referred to the Board of Trustees for study.

HOUSE ACTION: Adopted. Resolution #15 was referred to the Board of Trustees for study.

Memorial Resolution

Richard I. Nevin, 1908-1987

Whereas, Almighty God has chosen to call from us His loyal servant, Richard I. Nevin, Executive Director Emeritus of the Medical Society of New Jersey; and

Whereas, as Executive Director and as an Honorary Member of the Society, Mr. Nevin served the members of this Society and the people of New Jersey; and

Whereas, his actions demonstrated humanitarian concerns, vision, caring, and true gentleness; and

Whereas, he has left to us a standard of excellence to pursue; now therefore be it

Resolved, that the Medical Society of New Jersey express its profound sorrow at the death of Mr. Nevin, and extend to his beloved wife and family its heartfelt sympathy; and be it further

Resolved, that this Resolution be spread upon the minutes of this meeting, and a copy, suitably prepared, be presented to his bereaved family in heartfelt sympathy.

Received by the House with sorrowful concurrence.

Informational Report

Senior Citizens Task Force

A. RALPH KRISTELLER, MD, CHAIRMAN

The Senior Citizens Task Force continued in its dual purpose of creating a forum which affords an opportunity for the elderly to express to physicians their concerns regarding the delivery of health care, and creating an understanding of how current and proposed regulations impact on the delivery of health care to the elderly.

During the past year, speakers were invited to address the Task Force on a myriad of topics relevant to the delivery of quality health care. Topics and speakers included:

- "Malpractice," Peter Sweetland, President, Medical Inter-Insurance Exchange of New Jersey
- "The Board of Medical Examiners," Frank Malta, MD, President, New Jersey Board of Medical Examiners
- "The Hospital Crisis," Louis P. Scibetta, President, New Jersey Hospital Association
- "Physician Impairment," Edward G. Reading, MDiv, CAC, Assistant Director, Medical Society of New Jersey's Physician's Health Program
- "Medicare Regulations," Joseph J. Czarnecki, Resident Health Insurance Representative, Health Care Financing Administration
- "Economics of Medicine," Howard S. Berliner, ScD, Assistant Commissioner of the Division of Research, Policy, and Planning, New Jersey Department of Health

On October 8, 1987, the Task Force conducted its second annual forum entitled, "Seniors and Physicians: Vitalizing the Relationship." More than 200 attendees heard the keynote speaker, New Jersey State Senator Richard Van Wagner (D), 13th Legislative District, and participated in any one of three workshops: "Improving Access," "Assuring Quality," or "Identifying Costs."

Although the House of Delegates mandated a yearly forum, the Task Force felt that the success of the past two forums warranted an attempt to have two such programs a year. Consequently, a forum entitled, "Quality Health Care: A Guide for Its Retention," was planned for April 6, 1988. Unfortunately, the forum had to be cancelled due to low advanced registration.

The Task Force chose to express its thoughts in letters to the New Jersey Congressional Delegation on two occasions: 1) disapproval of proposed change in procedure for Administrative Law Judge hearing HCFA appeals; and 2) request investigation into sharp increase in denials of Home Health Care Medicare claims. On another occasion, a letter was sent to Governor Kean requesting monetary relief for New Jersey hospitals.

The Task Force meetings and annual forums continue to aim at strengthening mutual trust and understanding between the elderly and physicians.

Offices Filled By Election

Office	Term	Nominee and County
President-Elect	1 year	Paul J. Hirsch, MD, Somerset
1st Vice-President	1 year	Douglas M. Costabile, MD, Union
2nd Vice-President	1 year	Joseph A. Riggs, MD, Camden
Trustees		
1st District	3 years	Fred M. Palace, MD, Morris
4th District	3 years	Louis L. Keeler, MD, Camden
4th District	3 years	Edwin W. Messey, MD, Burlington
5th District	3 years	Shah M. Chaudhry, MD, Cape May
Judicial Councilor		
3rd District	3 years	Louis G. Fares, MD, Mercer
AMA Delegates		
	2 years	Ralph J. Fioretti, MD, Bergen
	2 years	Frederick W. Durham, MD, Camden
	2 years	Palma E. Formica, MD, Middlesex
	2 years	Karl T. Franzoni, MD, Mercer
	2 years	John S. Madara, MD, Salem
	2 years	Henry J. Mineur, MD, Union
	2 years	Edward A. Schauer, MD, Monmouth
AMA Alternate Delegates		
	1-1/2 years*	Harry M. Carnes, MD, Camden
	2 years	Michael M. Heeg, MD, Mercer
	2 years	Joseph N. Micale, MD, Hudson
	2 years	Irving P. Ratner, MD, Burlington
	2 years	Joseph A. Riggs, MD, Camden
	2 years	Robert H. Stackpole, MD, Union
	2 years	George L. Triebenbacher, MD, Ocean
Administrative Councils		
Legislation:		
1st District	2 years	George J. Hill, MD, Essex
2nd District	2 years	John J. Hosay, Jr, MD, Hudson
3rd District	2 years	Gabriel F. Sciallis, MD, Mercer
4th District	2 years	William V. Harrer, MD, Camden
Medical Services		
1st District	2 years	Albert Minzter, MD, Union
2nd District	2 years	Joseph W. Fleisher, MD, Hudson
3rd District	2 years	B. Ralph Wayman, Jr, MD, Mercer
4th District	2 years	Lindsay L. Pratt, MD, Camden
Mental Health		
1st District	2 years	Rita R. Newman, MD, Essex
2nd District	2 years	Vacancy to be filled by Board
4th District	2 years	Kenneth J. Rubin, MD, Monmouth
5th District	2 years	N.J. George, MD, Cumberland
Public Health		
1st District	2 years	Richard R. Lorber, MD, Union
2nd District	2 years	Maceo M. Howard, MD, Hudson
3rd District	2 years	Lawrence D. Frankel, MD, Middlesex
4th District	2 years	Mary F. Campagnolo, MD, Burlington
Public Relations		
1st District	2 years	Charles H. Arnoldi, Jr, MD, Essex
3rd District	2 years	Leticia V. deCastro, MD, Middlesex
4th District	2 years	Blackwell Sawyer, Jr, MD, Ocean
6th Member	2 years	Harry H. Brunt, Jr, MD, Monmouth
Standing Committees		
Annual Meeting		
	2 years	John P. Mudry, MD, Bergen
	2 years	Frank R. Romano, Sr, MD, Union
Auxiliary Advisory		
	2 years	Vacancy to be filled by Board
	2 years	Richard R. Lorber, MD, Union
Finance and Budget		
	2 years	George L. Triebenbacher, MD, Ocean
	2 years	B. Ralph Wayman, Jr, MD, Mercer
Medical Education		
	2 years	Paul C. Royce, MD, Monmouth
	2 years	Sanford H. Vernick, MD, PhD, Monmouth
Membership Services		
	2 years	**Vacancy to be filled by Board
	2 years	Donald J. Cinotti, MD, Hudson
Publication		
	2 years	Morris Soled, MD, Hudson
	2 years	William V. Harrer, MD, Camden

*Unexpired term of S. Thomas Carter, Jr, MD.

**Vacancy created by notification from Mohan Makhija, MD, Monmouth County, on February 25, 1988 (subsequent to Nominating Committee meeting), that he does not wish to be considered a nominee.

Official Attendance Report

County	Delegates	Members	Total
Atlantic	7	1	8
Bergen	41	26	67
Burlington	13	2	15
Camden	22	6	28
Cape May	2	-	2
Cumberland	3	5	8
Essex	55	33	88
Gloucester	3	1	4
Hudson	17	10	27
Hunterdon	1	1	2
Mercer	19	11	30
Middlesex	23	9	32
Monmouth	16	8	24
Morris	12	10	22
Ocean	8	4	12
Passaic	27	16	43
Salem	1	1	2
Somerset	4	1	5
Sussex	4	2	6
Union	32	16	48
Warren	2	-	2
Fellows and Officers	14	-	14
	<u>326</u>	<u>163</u>	<u>489</u>
Delegates Specialty Societies	7		7
Delegate MSNJ Student Association	1		1
Delegate MSNJ Resident Association	-		-
	<u>334</u>		
Physician Guests			15
Total Physician Registration			512
Auxiliary			144
Medical Students			5
Visitors			148
Exhibitors			56
Total Registration			865

Three-Year Comparative Registration Figures

Year	Physicians	Others	Total
1988	512	353	865
1987	326	283	609
1986	349	310	659

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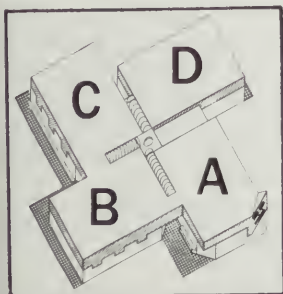


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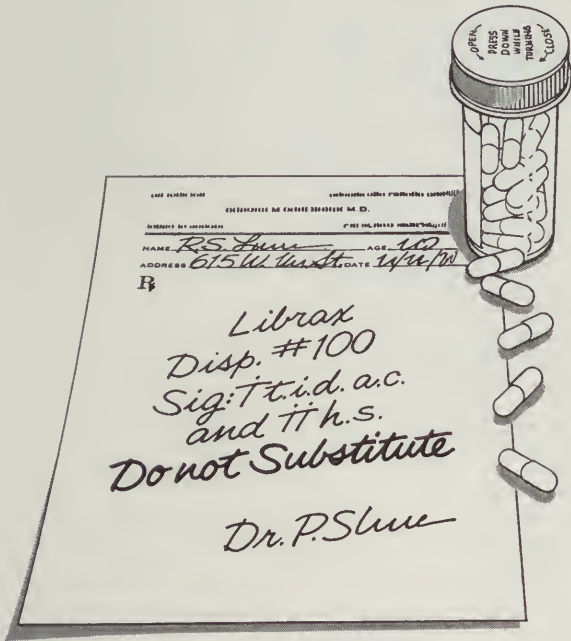
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As with all anticholinergics, inhibition of lactation may occur. Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such

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Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

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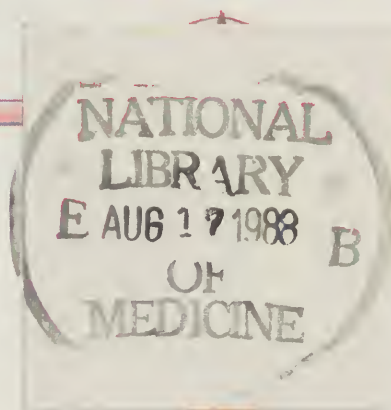
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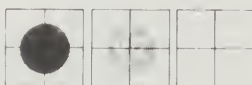
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Warning: Generally, this drug is not proposed for use in females and certainly not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

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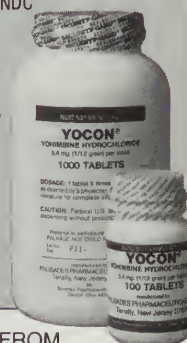
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

AUGUST 1988

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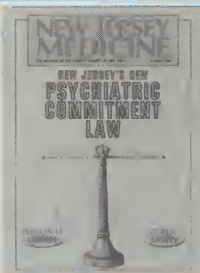
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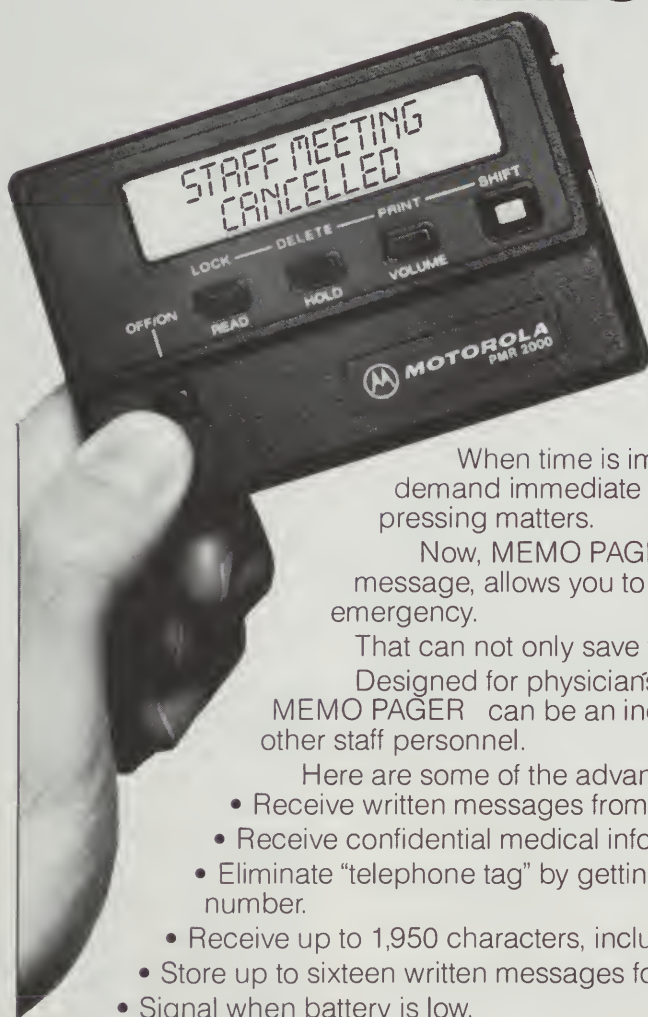
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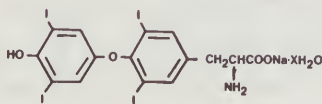
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DESCRIPTION:

Each LEVOXINE (Levothyroxine Sodium, USP) tablet contains synthetic crystalline levothyroxine sodium (L-thyroxine). L-thyroxine is the principal hormone secreted by the normal thyroid gland. Chemically, L-thyroxine is designated as L-tyrosine, O-(4-hydroxy-3, 5-diiodophenyl) - 3,5-diiodo-, monosodium salt, hydrate. The molecular formula is $C_{15}H_{10}I_2N_2NaO_4$ and the structural formula is:



CLINICAL PHARMACOLOGY:

The principal effect of thyroid hormones is to increase the metabolic rate of body tissues.

The thyroid hormones are also concerned with growth and development of tissues in the young.

The major thyroid hormones are L-thyroxine (T_4) and L-triiodothyronine (T_3). The amounts of T_4 and T_3 released from the normally functioning thyroid gland are regulated by the amount of thyrotropin (TSH) secreted from the anterior pituitary gland. T_4 is the major component of normal thyroid gland excretions and is therefore the primary determinant of normal thyroid functions. T_4 acts as a substrate for physiologic deiodination to T_3 in the peripheral tissues. The physiologic effects of thyroid hormones are mediated at the cellular level primarily by T_3 .

LEVOXINE (L-thyroxine) tablets taken orally provide T_4 which upon absorption can not be distinguished from T_4 that is secreted endogenously.

INDICATIONS AND USAGE:

LEVOXINE (L-thyroxine) tablets are indicated as replacement or supplemental therapy for diminished or absent thyroid function (e.g., cretinism, myxedema, nontoxic goiter or hypothyroidism generally, including the hypothyroid state in children, in pregnancy and in the elderly) resulting from functional deficiency, primary atrophy, from partial or complete absence of the gland or from the effects of surgery, radiation or antithyroid agents. Therapy must be maintained continuously to control the symptoms of hypothyroidism.

CONTRAINDICATIONS:

L-thyroxine therapy is contraindicated in thyrotoxicosis, acute myocardial infarction and uncorrected adrenal insufficiency.

WARNINGS:

Drugs with thyroid hormone activity, alone or together with other therapeutic agents, have been used for the treatment of obesity. In euthyroid patients, doses within the range of daily hormonal requirements are ineffective for weight reduction. Larger doses may produce serious or even life-threatening manifestations of toxicity, particularly when given in association with sympathomimetic amines such as those used for their anorectic effects.

PRECAUTIONS:

General — Caution must be exercised in the administration of this drug to patients with cardiovascular disease. Development of chest pains or other aggravation of the cardiovascular disease requires a reduction of dosage.

LEVOXINE (L-thyroxine) 100 mcg (0.1 mg), 200 mcg (0.2 mg) and 300 mcg (0.3 mg) tablets contain FD & C Yellow No. 5 (tartrazine) which may cause allergic-type reactions (including bronchial asthma) in certain susceptible individuals. Although the overall incidence of FD & C Yellow No. 5 (tartrazine) sensitivity in the general population is low, it is frequently seen in patients who also have aspirin hypersensitivity.

Information For The Patient — Patients on thyroid preparations and parents of children on thyroid therapy should be informed that:

1. Replacement therapy is to be taken essentially for life, with the exception of cases of transient hypothyroidism, usually associated with thyroiditis, and in those patients receiving a therapeutic trial of the drug.
2. They should immediately report during the course of therapy any signs or symptoms of thyroid hormone toxicity, e.g., chest pain, increased pulse rate, palpitations, excessive sweating, heat intolerance, nervousness, or any other unusual event.
3. In case of concomitant diabetes mellitus, the daily dosage of antidiabetic medication may need readjustment as thyroid hormone replacement is achieved. If thyroid medication is stopped, a downward readjustment of the dosage of insulin or oral hypoglycemic agent may be necessary to avoid hypoglycemia. At all times, close monitoring of urinary glucose levels is mandatory in such patients.

4. In case of concomitant oral anticoagulant therapy, the prothrombin time should be measured frequently to determine if the dosage of oral anticoagulants is to be readjusted.

5. Partial loss of hair may be experienced by children in the first few months of thyroid therapy, but this is usually a transient phenomenon and later recovery is usually the rule.

Laboratory Tests — The patient's response to thyroid replacement may be followed by laboratory tests such as serum thyroxine (T_4), serum triiodothyronine (T_3), free thyroxine index and thyroid stimulating hormone (TSH) blood levels.

Drug Interactions — In patients with diabetes mellitus, addition of thyroid hormone therapy may cause an increase in the required dosage of insulin or oral hypoglycemic agents. Therefore, patients with diabetes mellitus should be observed closely for possible changes in antidiabetic drug dosage requirements.

Patients stabilized on oral anticoagulants who are found to require thyroid replacement therapy should be watched very closely when therapy is started. If a patient is truly hypothyroid, it is likely that a reduction in anticoagulant dosage will be required. No special precautions appear to be necessary when oral anticoagulant therapy is begun in a patient already stabilized on maintenance thyroid replacement therapy.

Cholestyramine binds both T_4 and T_3 in the intestine, thus impairing absorption of these thyroid hormones. In vitro studies indicate that the binding is not easily removed. Therefore, four to five hours should elapse between administration of cholestyramine and thyroid hormones.

Estrogens tend to increase serum thyroxine-binding globulin (TBG). In a patient with a non-functioning thyroid gland who is receiving thyroid replacement therapy, free thyroxine may be decreased when estrogens are started thus increasing thyroid requirements. However, if the patient's thyroid gland has sufficient function the decreased free thyroxine will result in a compensatory increase in thyroxine output by the thyroid. Therefore, patients without a functioning thyroid gland who are on thyroid replacement therapy may need to increase their thyroid dose if estrogens or estrogen containing oral contraceptives are given.

Drug/Laboratory Test Interactions — The following drugs or moieties are known to interfere with laboratory tests performed on patients taking thyroid hormone: androgens, corticosteroids, estrogens, oral contraceptives containing estrogens, iodine-containing preparations, and the numerous preparations containing salicylates.

1. Changes in TBG concentration should be taken into consideration in the interpretation of T_4 and T_3 values. In such cases, the unbound (free) hormone should be measured. Pregnancy, estrogens, and estrogen-containing oral contraceptives increase TBG concentrations. TBG may also be increased during infectious hepatitis. Decreases in TBG concentrations are observed in nephrosis, acromegaly, and after androgen or corticosteroid therapy. Familial hyper- or hypo-thyroxine-binding-globulinemias have been described. The incidence of TBG deficiency approximates 1 in 9000. The binding of thyroxine by thyroid-binding prealbumin (TBPA) is inhibited by salicylates.

2. Medical or dietary iodine interferes with all in vivo tests of radio-iodine uptake, producing low uptakes which may not be reflective of a true decrease in hormone synthesis.

3. The persistence of clinical and laboratory evidence of hypothyroidism in spite of adequate dosage replacement indicates either poor patient compliance, poor absorption, excessive fecal loss, or inactivity of the preparation. Intracellular resistance to thyroid hormone is quite rare.

Carcinogenesis, Mutagenesis, And Impairment Of Fertility

Of Fertility — A reportedly apparent association between prolonged thyroid therapy and breast cancer has not been confirmed and patients on thyroid for established indications should not discontinue therapy. No confirmatory long-term studies in animals have been performed to evaluate carcinogenic potential, mutagenicity, or impairment of fertility in either males or females.

Pregnancy — Category A — Thyroid hormones do not readily cross the placental barrier. The clinical experience to date does not indicate any adverse effect on fetuses when thyroid hormones are administered to pregnant women. On the basis of current knowledge, thyroid replacement therapy to hypothyroid women should not be discontinued during pregnancy.

Nursing Mothers — Minimal amounts of thyroid hormones are excreted in human milk. Thyroid is not associated with serious adverse reactions and does not have a known tumorigenic potential. However, caution should be exercised when thyroid is administered to a nursing woman.

Pediatric Use — Pregnant mothers provide little or no thyroid hormone to the fetus. The incidence of congenital hypothyroidism is relatively high (1:4,000) and the hypothyroid fetus would not derive any benefit from the small amounts of hormone crossing the placental barrier. Routine determinations of serum (T_4) and/or TSH is strongly advised in neonates in view of the deleterious effects of thyroid deficiency on growth and development.

Treatment should be initiated immediately upon diagnosis and maintained for life, unless transient hypothyroidism is suspected; in which case, therapy may be interrupted for 2 to 8 weeks after the age of 3 years to reassess the condition. Cessation of therapy is justified in patients who have maintained a normal TSH during those 2 to 8 weeks.

ADVERSE REACTIONS:

Adverse reactions are due to overdosage and are those of induced hyperthyroidism.

OVERDOSAGE — Excessive dosage of thyroid medication may result in symptoms of hyperthyroidism. Since, however, effects do not appear at once, the symptoms may not appear one to three weeks after the dosage regimen is begun. The most common signs and symptoms of overdosage are weight loss, palpitation, nervousness, diarrhea or abdominal cramps, sweating, tachycardia, cardiac arrhythmias, angina pectoris, tremor, headache, insomnia, intolerance to heat and fever. If symptoms of overdosage appear, discontinue medication for several days and reinstitute treatment at a lower dosage level.

Laboratory tests such as serum T_4 , serum T_3 and the triiodothyronine index will be elevated during the period of overdosage.

Complications as a result of the induced hypermetabolic state may include cardiac failure and death due to arrhythmia or failure.

TREATMENT OF OVERDOSAGE — Dosage should be reduced or therapy temporarily discontinued if signs or symptoms of overdosage appear. Treatment may be reinstituted at a lower dosage. In normal individuals, normal hypothalamic-pituitary-thyroid axis function is restored in 6 to 8 weeks after thyroid suppression.

Treatment of acute massive thyroid hormone overdosage aimed at reducing gastrointestinal absorption of the drugs a counteracting central and peripheral effects, mainly those increased sympathetic activity. Vomiting may be induced initially further gastrointestinal absorption can reasonably be prevented and barring contraindications such as coma, convulsions, loss of the gagging reflex. Treatment is symptomatic and supportive. Oxygen may be administered and ventilation maintained. Cardiac glycosides may be indicated if congestive heart failure develops. Measures to control fever, hypoglycemia, or fluid loss should be instituted if needed. Antiadrenergic agents, particularly propranolol, have been used advantageously in the treatment increased sympathetic activity. Propranolol may be administered intravenously at a dosage of 1 to 3 mg over a 10 minute period orally, 60 to 160 mg/day, especially when no contraindications exist for its use.

DOSAGE AND ADMINISTRATION:

The goal of therapy should be the restoration of euthyroidism judged by clinical response and confirmed by appropriate laboratory tests such as serum thyroxine (T_4), serum triiodothyronine (T_3), free thyroxine index and thyroid stimulating hormone (TSH) blood levels. The age and general condition of the patient and severity and duration of hypothyroid symptoms determine starting dosage and the rate of incremental dosage increase leading to a final maintenance dosage.

In otherwise healthy adults, the recommended initial dose is 25 to 100 mcg (0.025 to 0.1 mg) daily, while the predicted maintenance dose of 100 to 200 mcg (0.1 to 0.2 mg) daily may be achieved in two to three weeks.

In the elderly patient with long standing disease, evidence of myxedema, or evidence of cardiovascular dysfunction, the initial dose may be as little as 25 mcg (0.025 mg) per day. Incremental increases of 25 mcg (0.025 mg) per day at 3 to 4 week intervals may be instituted depending on patient response. It is physician's judgement of the severity of the disease and observation of patient response which determine the rate of dosage increase.

In infants and children there is a great urgency to achieve thyroid replacement because of the critical importance of thyroid hormone in sustaining growth and maturation. Despite smaller body size, the dosage needed to sustain a full rate of growth, development and general thriving is higher in the child than in the adult. The recommended daily replacement dosage of L-thyroxine in childhood is: 0-1 years: 9 mcg/kg; 1-5 years: 6 mcg/kg; 6-10 years: 4 mcg/kg; 11-20 years: 3 mcg/kg daily.

DOSAGE FORMS AVAILABLE:

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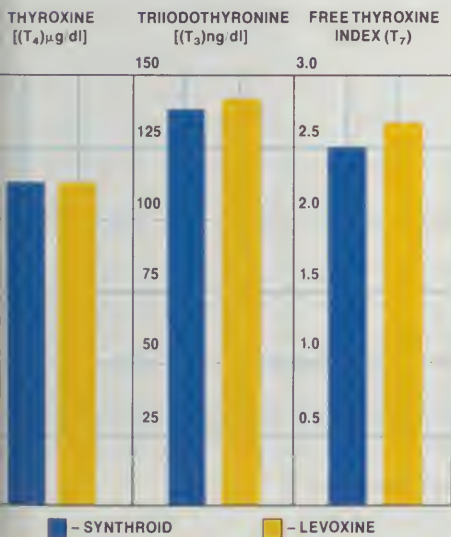
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* New Jersey Register March 21, 1988 (cite 20 N.J.R. 655)



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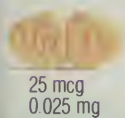
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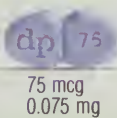
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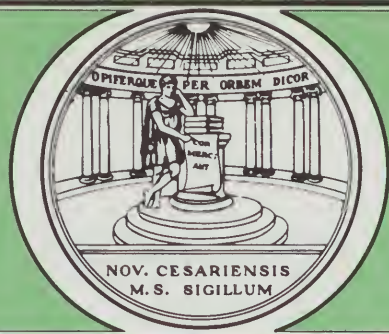
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THE MEDICAL SOCIETY OF NEW JERSEY

Volume 57

MEDICAL SOCIETY OF NEW JERSEY

Sports Medicine 1988

The Medical Society of New Jersey is sponsoring "Sports Medicine '88" on October 5, 1988, at Society headquarters, Two Princess Road, Lawrenceville, NJ. The program is open to physicians, school administration, athletic directors, coaches, nurses, trainers, and students. The program begins at 8:30 A.M. and includes: Indications and Limitations of Arthroscopy by Gary J. Savatsky, M.D.; Senior Athlete and Osteoporosis by Christine E. Haycock, M.D.; Liability of Sports Medicine by Steven I. Kern, Esq.; Back Problems of the Athlete by Martin Scott, D.O.; and a panel discussion. The program will conclude at 1:15 P.M. Deadline for registration is September 23, 1988; fees are: physicians: \$25; other personnel: \$20; and students: \$5.

MEDICAL SOCIETY OF NEW JERSEY

Peer Review, Utilization Review, and Quality Review Are the Practice of Medicine

The following letter was sent to Dr. Formica from Dr. Frank J. Malta, President of the State Board of Medical Examiners (SBME), dated May 26, 1988:

I am in receipt of your letter of May 19, 1988, which expresses the concern of the House of Delegates of the Medical Society of New Jersey in that third-party payors be held accountable to the same standards as are plenary licensed physicians.

Please note that SBME has taken the position that peer review activity which encompasses all of the components of decision making into the appropriateness of patient care requires a current plenary license. Therefore, peer review activity involves the practice of medicine. It would not be appropriate for third-party payors to be denied care based on cost consideration alone. Rather, care should be rendered based on the necessity of care in accordance with acceptable standard of practice. Therefore, the Board's position is that the final determination for the appropriateness of care is by physician and not by a nonphysician reviewer.

This Board has articulated that position in the past, noting that medical experts and those participating in peer review activities who fail to meet the standard of acceptable practice could be found guilty of professional misconduct and thereby sub-

ject to disciplinary action under the Medical Practice Act.

This Board has the responsibility by mandate of the Legislature to protect the health, safety, and welfare of the public. It is charged with the responsibility of investigating complaints from all arenas. It is apparent that concerns expressed by the Medical Society's House of Delegates were prompted by improper conduct by third-party payors or independent reviewers. The Board recommends that letters of complaint be filed with the Board for appropriate and expeditious investigation.

LEUKEMIA SOCIETY OF AMERICA

Grant Applications

The Leukemia Society of America is accepting applications for 1989 grants in basic science and clinical level research of leukemia and related diseases. Three awards are being offered: scholar grants totaling \$200,000 for five years to researchers with five years or more experience who have demonstrated their ability to conduct original investigations; special fellow grants totaling \$87,000 for three years for researchers in the intermediate stages of career development; and fellow grants of \$70,500 for three years for promising investigators with minimum or no prior experience. A Ph.D., M.D., or equivalent degree is required of all candidates.

Awards are not given to individuals who are receiving full institutional salary support.

The deadline for applications is September 1. Only one application in each grant category may be submitted from each faculty sponsor. Proposals for all categories of grants will be evaluated on a competitive basis by the Leukemia Society's Grant Review Subcommittee in late January 1989. Applicants should use only the most current forms to apply for grants. Funding for all grantees begins on July 1, 1989. For application forms and additional information, write to: Research Grant Coordinator, Leukemia Society of America, 733 Third Avenue, New York, NY 10017.

MEDICAL SOCIETY OF NEW JERSEY

Tort Reform: S-263; S-1845

On June 23, 1988, the Senate Judiciary Committee tabled consideration of the Statute of Limitations bill.

Major opponents of that bill were Senators Ambrosio, O'Connor, and Zane.

The Committee did vote to release S-1845, the periodic payments bill. Those voting in favor were Senators Codey, VanWagner, Orechio, Laskin, Lynch, and DiFrancesco. They all should receive messages of thank you from doctors.

We will be reconsidering our position and format on the statute of limitations later. There are certain concerns that must be accommodated. You will be advised later in this regard.

MEDICAL SOCIETY OF NEW JERSEY

Darkfield Services—Sexually Transmitted Diseases

This letter was received by Dr. Formica from Dr. Molly Joel Coye, New Jersey State Commissioner of Health, on May 24, 1988:

For many years, our sexually transmitted disease (STD) program staff were the sole providers of this diagnostic procedure for early lesion syphilis. Our staff would transport these microscopes in their cars and respond to service calls 24 hours a day, seven days a week. As you know, the field of sexually transmitted diseases has expanded tremendously from the time this policy was instituted. Today, there are more than 20 diseases and several syndromes that are contracted through sexual exposure.

In view of the need to address increasing numbers of cases, as well as additional diseases, we were forced to limit the amount of time our professional outreach staff was spending delivering these services. In 1986, we made a decision to schedule the availability of darkfield services provided by our staff only through large metropolitan STD clinics. In addition, we developed a darkfield microscopy training course which is offered by our Clinical Laboratory Improvement Services staff.

Physicians in private practice can access these services by calling their local health department or our STD program at 609/588-7526. I hope this information is helpful in clearing up any confusion concerning our darkfield microscopic services policy. Should you require additional information, please contact Mr. Clifford G. Freund of our STD Program at 609/588-7526.

MEDICAL SOCIETY OF NEW JERSEY

Right To Bill for Information

With the current emphasis on managed care in its various forms, the practicing physician receives numerous calls regarding preadmission certification, continued stay, discharge planning, disability evaluation, the prognosis, and other questions about a given patient. These calls are disruptive, annoying, and time consuming; they place a demand upon the physician which is not generally contemplated in the doctor's fee.

The House of Delegates adopted a resolution in April 1988, that recognized the right of physicians to bill for those information services required by third parties which go beyond those necessary to complete a health insurance claim form. We have articulated the sense of that resolution to the Commissioner of Labor and the Commissioner of Insurance.

MEDICAL SOCIETY OF NEW JERSEY

Letter to Commissioners Serraino and Merin

The following letter was sent to Commissioner Charles Serraino, New Jersey State Department of Labor, and Commissioner Kenneth D. Merin, New Jersey State Department of Insurance, signed by MSNJ Secretary Bernard Robins, M.D.:

Practicing physicians treating patients covered under disability plans, workers' compensation, health, auto, and general accident insurance are consistently being asked to write evaluations, reports, supply information, give status reports, and to update carriers or their agents as to treatment plans and the prognosis for the patient.

These requests are burdensome to the physician, and time consuming. They are not part of the physician's routine service, and are clearly not within the expressed intent and simple meaning of the statute which requires physicians to complete health insurance claim forms without additional charge to the patient.

The Board of Trustees believes that these requests are indeed additional matters, for which the physician is entitled to reasonable compensation.

We are advising our members, as well as you, of this position.

Thank you for understanding.

AMA-HOSPITAL MEDICAL STAFF SECTION

Dr. Weierman Is Elected

The Medical Society of New Jersey is proud to announce that Robert J. Weierman, M.D., has been elected to the American Medical Association-Hospital Medical Staff Section (AMA-HMSS) Governing Council. Dr. Weierman is an orthopaedic surgeon and a member of our Essex County Medical Society.

Dr. Weierman is an active participant at the HMSS Assembly and reference committee sessions, serving as reference committee chairman in 1986. In addition, he was a co-organizer of the New Jersey section and is immediate past-chairman of the AMA-HMSS-MSNJ and an alternate delegate to the AMA House of Delegates.

Born in 1942, Dr. Weierman received an undergraduate degree from St. Peter's College, Jersey City, and a medical degree from Georgetown University, Washington, D.C. He completed his internship and first-year surgical residency at Jersey Shore Medical Center, Neptune and an orthopaedic residency at UMDNJ. Presently, Dr. Weierman is attending at Hospital Center at Orange and Irvington General Hospital and an assistant attending at St. Mary's Hospital, Orange, and Saint Barnabas, Livingston; he is a clinical associate professor of orthopaedic surgery at UMDNJ-Newark. Dr. Weierman is a member of the American Medical Association and of the Academy of Medicine, a diplomate of the American Board of Orthopaedic Surgery, and a fellow of the American College of Orthopaedic Surgeons.

We congratulate Dr. Weierman.

MSNJ CONGRATULATIONS

Bernard Miller, M.D.

Congratulations to Bernard Miller, M.D., of New Brunswick who recently retired. Untold thousands of

patients have received benefits from a special DE-BOCA—"Deductible Entry in the Book of Charity Project." Dr. Miller provided not only medical service but drugs, food, fuel, and money to needy patients. What an example for all of us.

AMA ADVISERS, INC.

The Importance of Being Tax-Exempt

The Tax Reform Act of 1986 spawned what seems like a swarm of complications, exceptions, and special considerations. And, to the dismay of many taxpayers, it did not lower their tax bill in 1987. Against this backdrop of fewer tax shelters and higher taxes, it makes sense for most individuals to re-evaluate their investment portfolio with the goal of reducing their overall tax liability. After all, when you invest, it is not what you earn that counts, it is what you keep.

One of the best ways to achieve this investment goal is through investing in municipal bonds, which offer income free from federal, and in many cases, state and local income taxes.

How can you tell if you are a candidate for tax-free income? If the return from a tax-free investment delivers more spendable dollars than a comparable quality taxable investment, municipal bonds may be for you.

At what level of income does this occur? In the 28 percent marginal tax bracket, starting at about \$30,000, for a couple filing jointly. The higher the tax bracket, the more attractive the tax-free return.

To compare tax-free securities with other taxable fixed-income investments, it is necessary to determine the taxable equivalent yield. This is the yield an investor would have to earn on a taxable investment to equal what could be earned from a tax-free investment. Most brokers that deal with tax-free investments will be able to advise you on current tax-free yields and their equivalent taxable yield.

Although it sounds easy enough, the problem is that most investors neither have the time nor the expertise to select and monitor the most attractive and credit-worthy issues of municipal bonds. Fortunately, there are tax-free investment vehicles that eliminate these problems for the individual investor.

One of these is the Unit Investment Trust (UIT). The UIT is a fixed portfolio of professionally selected municipal bonds that offers customers income that is exempt from federal and, sometimes, state taxes. Many investors choose UITs because they prefer to know in advance exactly which securities will be held in the trust and what interest yield to expect.

A UIT offers investors these distinct advantages:

Professional Selection and Surveillance. Professionals select and monitor the trust until the last bond is called or sold or matures.

Payment Options. Investors can receive interest dis-

tributions monthly, quarterly, or semiannually, to meet their cashflow needs.

Optional Insurance. Some UITs are insured for guaranteed timely payment of principal and interest.

Convenience. All administrative work is done for you.

Liquidity. Units in a UIT always are redeemable at net asset value based on the market prices of the portfolio's underlying bonds, which may be more or less than the original purchase price, depending on interest rates at the time of purchase and redemption.

Diversification. UIT investment professionals select and monitor portfolios of bonds diversified by type, geographic location, revenue source, and purpose, which allows the investor to invest in a wide range of bonds, saving time and effort of making individual selections and reducing investment exposure to risk.

When an investor owns a portion of a UIT, units in that trust are owned. These units represent the investor's pro-rata share of the value of that trust. Unit investment trusts are sold in minimum investments ranging from \$1,000 to \$5,000. Investors pay a one-time sales charge, which varies depending on the amount invested. Also, there is no annual management fee, and no charge for redemption.

Unit trusts come in varying shapes and sizes. There are national portfolios and state portfolios, insured and uninsured trusts, and long, intermediate, and short-term maturities. There is something for almost every investment need.

Because of the UIT's steady stream of tax-free income, many investors use it as a monthly cash flow supplement. However, the UIT is a versatile investment vehicle that is well suited for various financial planning strategies—funding monthly mortgage payments or semiannual insurance premiums, for example.

A UIT also is appropriate for long-term savings plans—for retirement or college tuition—whereby the income from the trust is reinvested into a tax-free mutual or money market fund. This way, investors enjoy the benefits of compounding interest tax-free. For example, John Nuveen & Co. Incorporated, the largest sole sponsor/underwriter of unit investment trusts, offers a number of reinvestment options. Interest can be directed into national and state mutual and money market funds, where it continues to grow tax-free.

For the investor who is looking to reduce overall tax liability, build savings, or supplement income, a tax-exempt UIT is a wise investment choice which can be tailored to meet one's particular financial needs.

FINI

"Cooperation is doing with a smile what you have to do anyway."

PUBLIC AFFAIRS UPDATE

CLARK MARTIN*

***Malpractice Reform Gains Strength;
Medicaid Fees: A Small Step Forward;
Auto Insurance Reform Fizzles***

MALPRACTICE REFORM GAINS STRENGTH

Structured verdicts, a major element of the Society's push to reform medical malpractice laws, is a step closer to reality following the June 23 release of S-1845 from the Senate Judiciary Committee.

The bill, sponsored by Senator Raymond Lesniak (D-Elizabeth), would bring cost containment to medical malpractice cases. It would require judgments for future damages in excess of \$250,000 to be paid in installments over time, rather than as a lump sum. Past damages, such as lost income and medical expenses, still would be paid at settlement.

Significantly, the bill also provides that periodic payments for the plaintiff's health care costs and non-economic loss (pain and suffering) would cease if the plaintiff dies.

If enacted, S-1845 could bring a reduction in malpractice insurance premiums of 8 to 10 percent, according to the Medical Inter-Insurance Exchange of New Jersey (MIENJ).

Hundreds of physicians took part in a telephone and letter-writing campaign prior to the committee vote. Their efforts were made all the more significant by the bill's receiving just six favorable votes, exactly the number needed to be released from committee. Without the involvement of the physicians who participated in the lobbying campaign, it's likely that the bill would not have been voted out of committee. Even with the campaign, a second tort reform measure, which would have imposed a three-year statute of limitations on malpractice actions, was held in committee due to insufficient support.

Senators who voted in favor of S-1845 were Richard

J. Codey (D-West Orange), Donald DiFrancesco (R-Scotch Plains), Lee B. Laskin (R-Cherry Hill), John A. Lynch (D-New Brunswick), Carmen A. Orechio (D-Nutley), and Richard VanWagner (D-Red Bank).

Voting against the bill were Senators Gabriel M. Ambrosio (D-Lyndhurst), Edward T. O'Connor (D-Jersey City), and Raymond J. Zane (D-Woodbury), and abstaining were John H. Dorsey (R-Mountain Lakes) and William L. Gormley (R-Atlantic City).

Much more work lies ahead in order to secure passage of the bill in the Senate. MIENJ and the Society are working to have it posted for a vote in the fall session. The Bar Association and two powerful lawyer lobbies, LEGAL and ATLA, are vigorously opposing the measure.

MEDICAID FEES: A SMALL STEP FORWARD

New Jersey's fiscal 1989 budget, which took effect on July 1, contains an \$11.2 million increase in Medicaid fees for individual providers—the first such increase in 15 years.

While this falls short of what the Society had hoped for, at least it is a start. Governor Kean and Human Services Commissioner Drew Altman both are aware that too few physicians and other providers participate in the program. As a result, the majority of Medicaid patients can receive primary care only in costly hospital outpatient facilities and emergency rooms.

How far will the \$11.2 million go? We'll know soon. Altman told the Society's Medicaid Committee that his first goal is to raise the current \$7 office rate for primary care to \$13 to \$15. In order to achieve that level, it appears certain that revenues will have to be transferred from Medicaid's hospital account to individual providers.

Language in the budget requires Human Services to submit a new provider fee schedule to the Senate Revenue and Assembly Appropriations Committees. This information should help the Society's efforts to gain a more generous increase in next year's budget.

AUTO INSURANCE REFORM FIZZLES

Much like the Tyson-Spinks heavyweight fight, the first round of the Senate-Assembly bout to revamp the no-fault auto insurance law didn't last long. In the space of two weeks, each house had passed its own plan and rejected the other's.

However, in the seemingly endless battle over how to remold the law in order to reduce premiums, one point of agreement seems to have emerged: a medical fee schedule.





Both houses have passed bills which would apply a fee schedule to Personal Injury Protection (PIP) coverage, the portion of an auto policy which pays an injured driver's hospital and physician bills. The fee schedule currently under consideration would be based on Blue Shield. The legislation would permit balance billing.

The PIP fee schedule would be enacted only as part of an overall reform measure dealing with the question of when an injured party can sue a negligent driver for pain and suffering. At this writing, the Senate and Assembly are miles apart on that issue. Stay tuned.

*Mr. Martin is MSNJ's legislative consultant.



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Aspirin and other nonsteroidal anti-inflammatory drugs  are known to weaken mucosal defenses by inhibiting prostaglandin production. As a result, NSAID users may be more prone to duodenal ulcers.¹ For these patients, CARAFATE[®] (sucralfate/Marion) is first-line therapy that won't knuckle  under. Carafate rebuilds mucosal defenses, including endogenous prostaglandins, through a unique, nonsystemic mode of action. Carafate works by enhancing the body's natural healing ability while it protects damaged mucosa  from further injury. Carafate offers a local healing approach to a local problem, allowing patients to continue their NSAID therapy. So the next time you see an arthritis patient with a duodenal ulcer, prescribe nonsystemic Carafate:  therapy for the ulcer-prone patient.

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Please see brief summary of prescribing information and reference on adjacent page.

1337E8



BRIEF SUMMARY

CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate.

PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

Pregnancy: Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

OVERDOSAGE

There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED

CARAFATE (sucralfate) 1-gm tablets are supplied in bottles of 100 (NDC 0088-1712-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1712-49). Light pink scored oblong tablets are embossed with CARAFATE on one side and 1712 bracketed by C's on the other.

Reference:

1. Eliakim R, Ophir M, Rachmilewitz D: *J Clin Gastroenterol* 1987;9(4):395-399.

Another patient benefit product from



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JERSEY CITY
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LINDEN
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Liability News

New Informed Consent Supreme Court Decision; Beware of Hospital Corridor Prescribing; Past Malpractice May Be Kept from Uncle Sam's Eyes; Plan for Bringing Down Liability Costs

NEW JERSEY'S NEW "INFORMED CONSENT" SUPREME COURT DECISION

A patient who underwent a biopsy of the breast and excision of lymph nodes for suspected breast cancer developed lymphedema of the right arm and hand. The surgeon who performed the biopsy allegedly did not advise the patient of the risk of lymphedema. At trial, an expert witness for the plaintiff told the jury that the surgeon should have told the patient about this risk. The expert witness who testified on behalf of the physician told the jury that physicians consider the risk to be "too remote" a phenomenon to be discussed with their patients.

The jury found no liability on the part of the surgeon. The plaintiff and her husband appealed, arguing that the trial court erred in instructing the jury on the standard by which they must judge whether or not the patient's consent was an informed one. The appeal was ultimately decided by the Supreme Court of New Jersey on May 8, 1988. The high court's decision changes the law of informed consent in New Jersey. The changes affect the scope of what the physician must disclose, and will change the way cases of informed consent are presented to juries at trial.

The legal duty of a physician to obtain the informed consent of his patient has been a part of medical malpractice jurisprudence in New Jersey for two decades. In 1968, the Supreme Court of New Jersey affirmed the opinion of the Appellate Division in a case known as Kaplan versus Haines, 51 N.J. 404, aff'g 96 N.J. Super 242. In the Kaplan case, the court adopted

a standard of disclosure for informed consent that required the physician to disclose those risks that a reasonable physician in the community and of like training would customarily disclose in similar circumstances. This standard became known as the "professional" standard, since the scope of disclosure was clearly dependent upon physician custom and practice.

Breaking with the past, the Supreme Court of New Jersey rejected the "professional standard" in informed consent cases. In the case known as Largey versus Rothman, the high court characterized the "professional standard" as "anachronistic paternalism" at odds with the concept of a patient's right to self-determination. Instead, it adopted what is known as a "prudent patient" rule for disclosure. The "prudent patient" rule was first formulated in 1972 by a federal court in a case known as Canterbury versus Spence, 464, F.2d 772 (D.C., Civ.), cert. den. 409 U.S. 1064.

Under the law now adopted by New Jersey's highest court, physicians in the state no longer can rely solely upon the custom and practice of their profession in determining what risks or alternative treatment should be disclosed to patients. Rather, disclosure now must be measured by the patient's need to know of risks that are "material."

The law requires a physician "to warn of the dangers of proposed therapy" and to convey "information which the patient has every right to expect." The law also imposes a duty to make "reasonable disclosure of choices" with respect to treatment and "the dangers inherently and potentially involved." The new rule defines a "material" risk as one which a reasonable patient, in what the physician knows or should know to be a patient's position, would likely attach significance to in deciding whether to accept or forgo proposed therapy.

The new decision of the Supreme Court of New Jersey makes it easier and less expensive for a patient to bring a lawsuit alleging lack of informed consent. Under the former "professional standard," the patient was required to retain an expert witness who would testify at trial that the defendant physician failed to disclose what reasonable physicians of like training in the community would have told the patient under similar circumstances. The new "prudent patient" rule abolishes the requirement for the patient turned plaintiff to present expert testimony on informed consent. Nevertheless, nothing in the court's opinion is likely to prevent either the plaintiff or the defendant physician from presenting expert witness testimony. Experts may identify risks and characterize them as to their medical significance and degree of remoteness. Experts also may give testimony regarding patient concerns about particular risks.

Juries deciding informed consent cases in New Jersey must not only determine whether the plaintiff has proved that the physician failed to comply with the new standard for disclosure, but also whether or not such failure was the proximate cause of the plaintiff's

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are Director of the Department and Director of Special Projects, respectively.

injuries. The jury will be asked to decide whether or not a prudent person in the plaintiff's position would have submitted to treatment if suitably informed of all perils bearing significance. If the jury determines that adequate disclosure could reasonably be expected to have caused that person to decline the treatment because of the kind of risk or danger that resulted in harm, then causation is shown.

In essence, juries will be asked to assess the "reasonableness" of a plaintiff's testimony that he would have refused the treatment had the risk been disclosed. The law requires that a patient must be informed of his problem in terms understandable to him. The patient must also be told what treatment is proposed, and what the inherent risks and benefits are regarding the proposed treatment. Any alternative treatments and associated risks and benefits must also be discussed. The patient should be told the prognosis if no treatment is undertaken. Patients should be encouraged to ask questions so that the physician may determine what risks are "material" to the patient's decision.

The new decision of the Supreme Court of New Jersey requires disclosure of those risks or complications likely enough to happen so that a reasonable patient in similar circumstances might refuse the proposed treatment or seek alternative treatment. A patient who sues a physician for lack of informed consent no longer will be required to retain an expert witness to testify at trial. (Madelyn S. Quattrone, J.D., George & Korin, P.A., Woodbury, NJ)

BEWARE OF HOSPITAL CORRIDOR PRESCRIBING

Does the following scenario sound familiar? You are in the hospital making rounds and in the hall you meet a nurse you have known and worked with for years. After the usual exchange of pleasantries, she says, "Oh, doctor, I have got this terrible cold. Do you think you can give me a prescription for something? We are too busy in here for me to take time off to go see my regular doctor." (Sometimes, the request is not even for the hospital employee, but for a spouse or child.) You whip out a prescription pad and write an appropriate prescription. Remedy in hand, the nurse thanks you as she heads for the pharmacy, and you go on with your rounds.

There is nothing unique about this incident; the scene probably is replayed daily in hospitals everywhere. However, the Pennsylvania Medical Society Liability Insurance Company's (PMSLIC) all-physician Claims Committee has seen this scenario result in subsequent litigation against the physician involved and believes a word of caution is necessary in this regard.

A somewhat risky practice from a medical standpoint, "corridor prescribing" also is a bad habit to get into from a medical-legal point of view. Prescribing without benefit of a physical examination, often

without knowing the patient's history or, in cases involving requests for other family members, not even knowing the patient, is potentially legally dangerous for the physician. Additionally, it is fairly safe to assume that these hallway prescriptions are rarely documented anywhere, especially if the employee in question is not a regular patient of the physician. And, a minor distraction in the busy daily routine of a physician, the incident is soon out-of-mind, unrecorded, and forgotten.

Negligent drug therapy is one of the most commonly seen allegations in PMSLIC's claims experience. Prescribing as described above only adds to the inherent risks of drug therapy. The Claims Committee sees these cases years after the fact, after a hallway prescription results in an adverse side effect or reaction, and the employee sued the physician for negligent prescribing. At that point in time, the physician involved has no record of the prescription and probably no recollection of the incident to aid his defense.

Please be very cautious and discriminating in this practice; do not earn a reputation among hospital employees as being an easy target for on-the-spot prescribing. And, by all means, make a note of all such corridor transactions immediately, to be transcribed or at least filed for future reference should subsequent problems or litigation arise. (*Patient Rx Newsletter*, Pennsylvania Medical Society Liability Insurance Company, May 1988, Volume 10, No. 3)

PAST MALPRACTICE MAY BE KEPT FROM UNCLE SAM'S EYES

Doctors who have been sued or disciplined for medical negligence may have a clean slate, as far as the new national malpractice data bank is concerned. Under rules proposed by the Public Health Service, insurers, state licensing boards, and hospitals would not have to report malpractice payments or disciplinary actions relating to licensure and clinical privileges if they occur before the data bank's start-up date—now expected early next year. (*Medical Economics*, May 2, 1988)

PLAN FOR BRINGING DOWN LIABILITY COSTS

Congress is considering a bill to set one standard of liability for physicians and other professionals nationwide. Among other things, the statute would encourage alternative ways to resolve claims, limit attorney's fees based on a sliding scale, and hold plaintiff's attorneys liable for frivolous suits. Punitive damages would be awarded only if there is "clear and convincing evidence" that a physician exhibited malicious and reckless disregard for the patient's safety. If punitive damages were awarded, the plaintiff's share would be limited to no more than three times the compensatory damages; the balance would be paid to the state. (*Medical Economics*, May 2, 1988)

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Time and Time Again

PALMA E. FORMICA, M.D.*

Tips for keeping reception room delays to a minimum is the subject of this essay by our president.

In reviewing a complaint about patient waiting time, I thought it might be appropriate to give physicians some tips to consider to alleviate this problem.

Start on Time. Plan ahead to arrive on time for office hours. Look over the schedule. How often have you been late in the past month to start hours? I cannot tell you how many times I have heard someone say, "I must hurry, I am late for hours!" If you have a meeting scheduled from noon to 1 P.M. every third Tuesday, then those hours should be rescheduled accordingly.

Review the Appointment Book. Most of us have an excellent receptionist, but under pressure from patients, she may have started to add to or to change the appointment schedule.

Review Instructions for Making Appointments. When was the last time you provided instructions for

your receptionist? Have you relegated this to the office manager, or is the receptionist expected to be clairvoyant? Are your instructions written in a manual? If so, when were they updated?

Identify Patients or Procedures which Normally Require More Time. Do you have talkative patients, patients requiring counseling, new patients, or complete patient examinations? Have the receptionist block out extra time with these considerations in mind.

Do a Time Study on a Typical Day. Have the receptionist indicate the time of arrival, appointment time, when the patient entered the examining room, time the physician entered the room, and of completion of the visit. This system will pinpoint areas of delay.

How Do You Handle Emergencies? Do you allow a block of time for emergencies, phone calls, or to catch up on work?

What about Walk-ins? Do you have a procedure? What about unavoidable delays? Do you telephone the office to apprise them of the delay? Do you have the staff notify patients who are waiting to give them the opportunity of rescheduling? If they decide to wait, do you have the office staff call those who have not arrived to inform them of the delay? Do you personally acknowledge the delay and apologize for the inconvenience?

Is the Reception Area Comfortable? Is there a sufficient quantity of timely reading material or patient education material?

Is Staffing Sufficient and Efficient? Are special arrangements made for those who need more time, or those who cannot afford to take time off from work to see you?

Are All Members of the Staff Courteous and Pleasant? Keep an ear open for patient complaints, and reward those staff members who are praised.

Is the Receptionist a Dragon-lady or a Darling? Your office represents you: your caring and concern are first presented to the public by your staff.

Keep an Eye on the Clock. If the visit drags on too long, have a prearranged set of instructions for the nurse, i.e. five minutes over, a tap on the door with a message that there is a phone call.

*Correspondence may be addressed to Dr. Palma Formica, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648.

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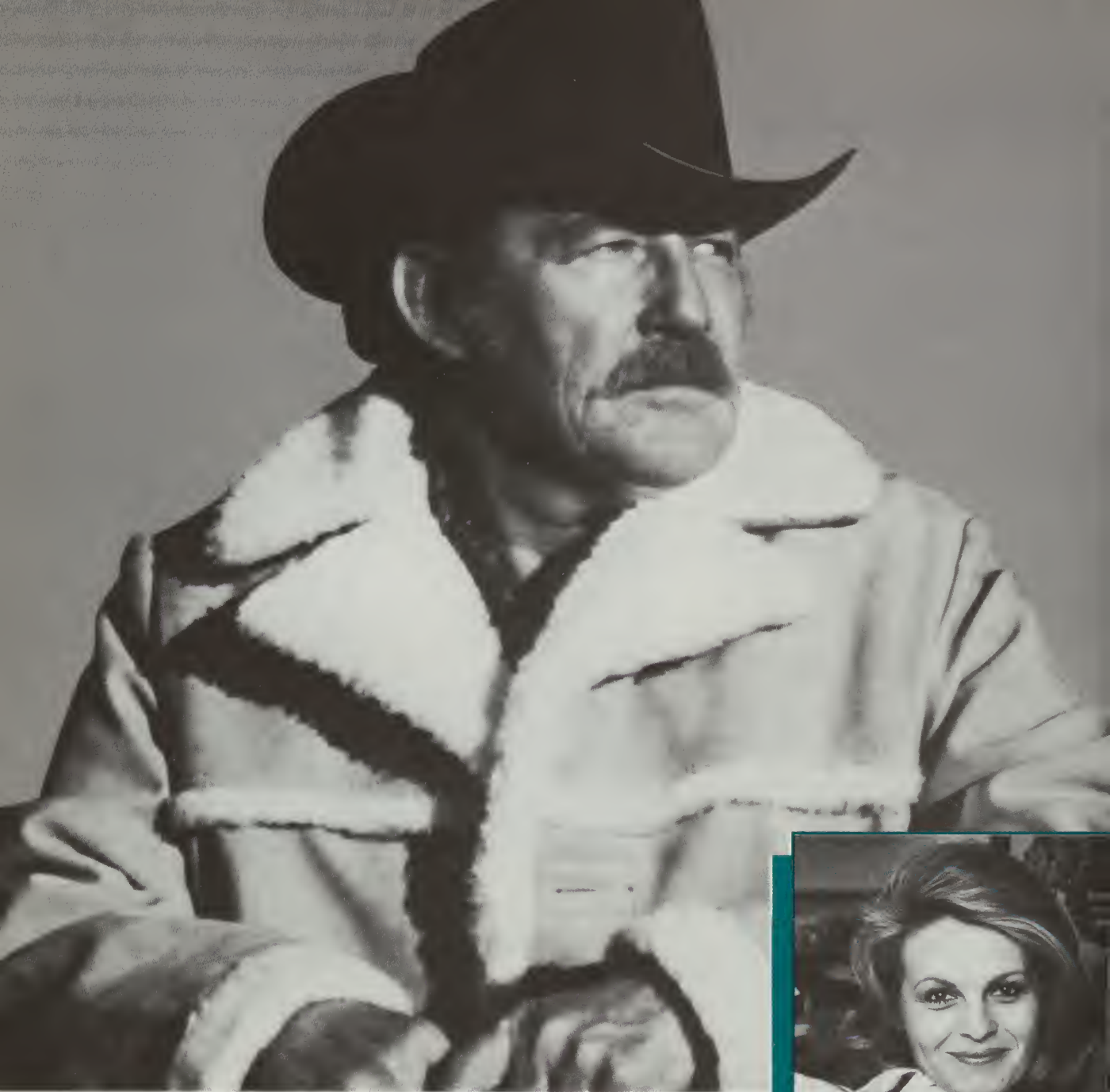
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Vicissitudes

HOWARD D. SLOBODIEN, M.D.

The New Jersey Division of the American Cancer Society, in its spring issue, recommends increased physician and patient awareness of the value of routine screening mammography.¹ It says, "There is a need for at least 1.2 million screening mammograms annually in New Jersey."

This publication comes in the face of others suggesting changes in the recommendations promulgated by the American Cancer Society, the American College of Radiology, and the American Medical Association. These recommendations include a baseline mammogram between ages 35 and 40, mammograms every one to two years between ages 40 and 50, and yearly mammograms beginning at age 50.

The first of the reports alluded to suggests that the intervals between breast x-rays in the latter two groups be reversed, i.e. that yearly mammograms be done between ages 40 and 50 and that the interval be changed to every two years thereafter. Moskowitz presents a cogent and logical argument for this approach;² if screening mammography can decrease mortality from breast cancer by detecting lesions before they are

palpable, it makes sense to do them more frequently when the rate of growth of the tumor tends to be more rapid. The rate of growth of breast cancer seems to be faster before age 50 and slower after that age; hence, reverse the original recommendations. Perfectly plausible, isn't it? (Others have written to agree.)

But now come two other articles! The first article is by Eddy et al.³ and the second article, an editorial by Bailar,⁴ comments on the Eddy study; these decry the value of any mammographic screening in women under age 50. Their conclusions: the benefits of mammography in this younger age group may not be significant when all elements are considered, unless positive risk factors are present in the individual woman. Eddy et al.³ suggest a flexible approach, with options to be decided by collaborative agreement between the physician and the patient. Bailar, though, is more emphatic,⁴ recommending the guidelines of the U.S. Preventive Services Task Force^{5,6} be followed, to "perform yearly clinical breast examination from age 40 onward, and begin annual mammography at age 50." Does this answer the questions raised by the DATTA study⁷ in 1987, or are we still in limbo?

The "rock and hard place" position looms before us. What is the proper recommendation to give our patients? Do we order screening mammograms yearly, every one to two years or not at all (with exceptions) in women ages 40 through 49? Do we order mammograms yearly, every one to two years, or biennially in women who have reached age 50? Although it may be a secondary consideration, how will the courts interpret conflicting recommendations? And, if 1.2 million yearly mammograms are needed in New Jersey, can we justify the expenditure of \$72 million to \$185 million annually, with a large part of that in the below 50 age group?

Your comments would be appreciated. As this goes to press, federal health officials are urging creation of a national breast cancer screening program.

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NEW JERSEY'S NEW PSYCHIATRIC COMMITMENT LAW

JAMES E. GEORGE, M.D., J.D., MADELYN S. QUATTRONE, J.D., CARMELLA P. KEENER, J.D., WOODBURY*

Psychediatric commitment is a controversial subject due, in large part, to the important public policy concern that a person not be deprived of personal liberty without reasonable due process protections. Because involuntary commitment involves deprivations of liberty, the state attempts to balance the basic value of liberty with the need for safety and treatment. The law of psychiatric commitment creates this balance by setting standards and creating procedural safeguards that ensure only those persons

who are dangerous to themselves, others, or property are involuntarily committed. (Section 1(b))**

A new psychiatric commitment statute will take effect in New Jersey on November 7, 1988, creating

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**All references are to Chapter 116, Laws of 1987, Assembly Number 1813, introduced February 3, 1986, approved May 7, 1987.

New Jersey's new psychiatric commitment law, designed to protect individual liberty and public health, safety, and welfare, provides mechanisms for the commitment of mentally ill individuals.

screening services which will serve as the entry point into the New Jersey public mental health services system (Figure).

The law provides clearer guidelines for the protection of individual liberty as well as public health and safety. The statute sets forth patient rights concerning advocacy and due process by requiring court hearings to determine whether initial or continued commitment is appropriate, and by providing patients with legal representation at those proceedings. In addition, the statute provides immunity from civil liability for certain individuals involved in the detention or transportation of an individual for the purpose of assessment or treatment.

POLICY AND PURPOSE

Under the U.S. Constitution, states have "police power" allowing them to make laws to protect the health, safety, and welfare of their citizens. Thus, the state of New Jersey has sought, with this law, to provide for the voluntary admission and the involuntary commitment of mentally ill individuals who are dangerous to themselves, to others, or to property. Such a law is necessary because some mentally ill individuals do not seek medical treatment or are not able to benefit from treatment provided on an outpatient basis. Therefore, the law provides for public services and facilities to meet the needs of those mentally ill individuals as well as the general public.

The statute sets forth several policies of the state: (1) Persons in mental health institutions should receive care in accordance with the highest professional standards and which will enable return to the community as soon as clinically possible. (2) The public mental health system should be developed in a manner which will protect individual liberty, provide for advocacy and due process for persons receiving treatment, and insure that treatment is consistent with the individual's clinical condition. (3) Counties are encouraged to develop screening services as the entry point to the public mental health care system, and short-term care facilities.

The statute indicates that the development and use of screening services and short-term care facilities are necessary "to strengthen the statewide public mental health care system, lessen inappropriate hospitalization and reliance on psychiatric institutions, and enable state and county facilities to provide the rehabilitative care needed by some mentally ill persons following their receipt of acute care." (Section 1(d))

APPLICABILITY

The provisions of the statute apply to all adults involuntarily committed to a short-term care facility, psychiatric facility, or special psychiatric hospital, and all adults voluntarily admitted from a screening service to a short-term care facility or psychiatric facility. The law does not apply to adults voluntarily admitted to psychiatric units in general hospitals or special psychiatric hospitals, except under certain, limited circumstances. (Section 3)

DEFINITIONS

The procedure outlined in the statute applies to those mentally ill persons who are dangerous to themselves, to others, or to property. "Dangerous to one's self" is defined to mean that "by reason of mental illness, the person has threatened or attempted suicide or serious bodily harm, or has behaved in such a manner as to indicate that the person is unable to satisfy his need for nourishment, essential medical care, or shelter, so it is probable that substantial bodily injury, serious physical debilitation, or death will result within the reasonably foreseeable future; however, no person shall be deemed to be unable to satisfy his need for nourishment, essential medical care, or shelter if he is able to satisfy such needs with the supervision and assistance of others who are willing and available." (Section (2)(h))

"Dangerous to others or property" means "by reason of mental illness, there is a substantial likelihood that the person will inflict serious bodily harm upon another person or cause serious property damage within the reasonably foreseeable future. This determination shall take into account a person's history, recent behavior, and any recent act or threat." (Section (2)(i))

"In need of involuntary commitment" means that "adult who is mentally ill, whose mental illness causes the person to be dangerous to self or dangerous to others or property, and who is unwilling to be admitted to a facility voluntarily for care, and who needs care at a short-term care facility, psychiatric facility, or special psychiatric hospital because other services are not appropriate or available to meet the person's mental health care needs." (Section 2(m))

"Voluntary admission" means "that adult who is mentally ill, whose mental illness causes the person to be dangerous to self or dangerous to others or property and who is willing to be admitted to a facility volun-

tarily for care at a short-term care facility or psychiatric facility because other facilities or services are not appropriate or available to meet the person's mental health needs. A person also may be voluntarily admitted to a psychiatric facility if his mental illness presents a substantial likelihood of rapid deterioration in functioning in the near future, and if there are no appropriate community alternatives available and the psychiatric facility can admit the person and remain within its rated capacity." (Section 2(ee))

PROCEDURES

1. Evaluation.

Screening Service. The statute provides that the screening service will serve as the entry point into the public mental health services system. The screening service will undertake an assessment of the person believed to be in need of commitment to a short-term care facility, psychiatric facility, or special psychiatric hospital. The assessment may take place at the screening service's facility. If the person subject to screening is in need of involuntary commitment and is unwilling or unable to come to the screening service for assessment, an assessment may take place through an outreach visit.

If the screening service determines that involuntary commitment is necessary, a psychiatrist shall make a determination based on information provided by the screener and his own assessment as to whether the person is in need of commitment, and shall complete the screening certificate. If commitment is deemed necessary, the screening service then will determine the appropriate type of facility for the person. The screening service should arrange for commitment and transportation to the appropriate facility as soon as possible.

If the screening service determines the person is not in need of admission or commitment to a short-term care facility, psychiatric facility, or special psychiatric hospital, the screener shall refer the individual to an appropriate community mental health service, social services agency, or appropriate professional for inpatient care in the psychiatric unit of a general hospital.

The statute also provides for the involvement of law enforcement officers. The officer may take custody of a person and take the person immediately to a screening service if: a) on the officer's personal observation, he has cause to believe the person is in need of involuntary commitment; b) the mental health screener has certified after an outreach visit that the individual is in need of involuntary commitment and has requested that the individual be taken to the screening service for assessment; or c) the court orders that a person subject to conditional discharge who has failed to meet the conditions of that discharge be taken to the screening service for assessment. The involvement of the officer at the screening service may continue for as long as necessary to protect the safety of the person in custody and the safety of the community from which the person was taken. (Section 6)

Furthermore, the statute provides immunity from civil liability for the law enforcement officer, screening

service, or short-term care facility staff person or their respective employers who, in good faith, take reasonable steps to assess, take custody of, detain, or transport an individual for purposes of mental health assessment or treatment. (Section 7)

2. Admission.

The procedures governing admission to a short-term care facility, psychiatric facility, or special psychiatric hospital differ depending upon whether an admission is voluntary or involuntary. Involuntary admission can be accomplished only by referral from a screening service or by temporary court order. A voluntary admission is permissible only after the individual has been advised orally and in writing of the discharge provisions to which he will be subject and the possibility that the facility may initiate involuntary commitment proceedings for the person.

3. Involuntary Commitment.

Detention. The person admitted involuntarily on referral from the screening service without a temporary court order may be detained for no more than 72 hours from when the screening certificate was executed. During this time, the facility shall initiate court proceedings for the involuntary commitment of the person.

Initiation of Court Proceedings. The facility shall submit to the court a copy of the screening certificate and a clinical certificate completed by a psychiatrist on the person's treating team, but the same physician shall not sign both unless the psychiatrist has been unable to have another psychiatrist conduct the examination and execute the certificate.

Court proceedings for the involuntary commitment of an individual not referred by a screening service shall be initiated by the submission to the court of two clinical certificates, at least one of which is prepared by a psychiatrist. In contrast to the 72-hour period for which an individual referred by a screening service may be held, an individual who has not been referred by the screening service shall not be involuntarily committed without a temporary court order.

Standard of Proof. If the court finds no probable cause for involuntary commitment, it shall dismiss the proceedings and order the individual's discharge. If the court finds that there is probable cause for involuntary commitment, it shall issue a temporary order authorizing the admission or retention of the person in the custody of the facility pending a final hearing.

Patient's Rights. The statute enumerates the rights of a patient admitted (either voluntarily or involuntarily) to a short-term care facility, psychiatric facility, or special psychiatric hospital. These rights include examinations and services in the patient's primary means of communication, e.g. interpreter, sign language, verbal explanation of the reasons for admission, the availability of an attorney, and the right to be represented by an attorney. If the patient is unable to afford an attorney or is unrepresented, the appropriate government agency will provide and pay for an attorney.

4. Continued Involuntary Commitment.

Patient's Court Hearing. An individual involuntarily

committed shall receive a court hearing within 20 days from initial inpatient admission and shall have counsel present. Testimony will be received by the court from a psychiatrist on the patient's treating team who has examined the individual no more than five days prior to the hearing, regarding the need for involuntary commitment. Members of the individual's family may testify, if appropriate. The individual has the right to present evidence, to cross examine witnesses, and to have a hearing *in camera*, e.g. in a judge's chambers, or with spectators excused from courtroom if the individual so requests.

Standard of Proof. If the court finds by clear and convincing evidence that the patient needs continued involuntary commitment, it shall order such commitment and shall schedule a subsequent court hearing to take place only in the event the patient has not been administratively discharged by the institution on recommendation of his treating team.

If the court finds that the patient does not need continued involuntary commitment, it shall order the release of the patient by the facility within 48 hours.

If the court finds that the patient's history indicates a high likelihood of rehospitalization because of the patient's failure to comply with discharge plans, the court may discharge a patient subject to conditions recommended by the facility and staff, but such conditions shall be specific and their duration shall not exceed 90 days.

Periodic Reviews. A patient committed pursuant to a court order shall be afforded periodic court hearings to review the need for continued involuntary commitment.

5. Administrative Discharge.

The treatment team at a psychiatric facility, short-term care facility, or special psychiatric hospital shall administratively discharge a patient from involuntary commitment status if the treatment team determines the patient no longer needs involuntary commitment. The person discharged shall have a discharge plan designed by the treatment team and the patient. The patient shall receive followup care and interim financial assistance pending determination of public benefit entitlements when appropriate under regulations promulgated by the commissioner of the Department of Human Services.

6. Voluntary Patients.

At the patient's request, he shall be discharged by the treatment team within 48 hours or at the end of the next working day from the request, whichever is longer. However, the treatment team may determine that the patient needs involuntary commitment. In such a case, the treatment team shall initiate court proceedings under proper procedure. Thus, the facility shall detain the individual beyond the time prescribed above, i.e. the longer of 48 hours or end of next working day, only if the court has issued a temporary court order.

The voluntarily admitted patient has the same rights and privileges afforded involuntary patients. These rights include examinations and services in the patient's primary means of communication, verbal ex-

planation of the reasons for admission, and the right to be represented by an attorney (with the attendant right to have an attorney provided and paid for by the appropriate government agency).

CONCLUSION

While the new law may be interpreted as adding an additional bureaucratic layer to the process of psychiatric commitment, it has some potential benefits as well. This law provides guidelines for the balancing of public health, safety, and welfare against the right of personal liberty. The installation of the screening service as the entry point into the public mental health services system is intended to provide an additional safeguard so that only mentally ill persons are committed. In those situations in which a screening service has not referred an individual, the individual may not be committed, even temporarily, without a court order.

Physicians may enter the psychiatric admission/commitment process at many stages. In those cases in which the patient has not been referred by a screening certificate, court proceedings for commitment require two clinical certificates, at least one of which is signed by a psychiatrist. A physician who has evaluated a patient may be asked to sign the second clinical certificate certifying his belief that the individual is in need of psychiatric commitment. The physician also may come into contact with the individual as a result of the individual's admission to the psychiatric unit of a general hospital in cases in which the screening service has determined that admission or commitment to a short-term care facility, psychiatric facility, or special psychiatric hospital is unnecessary.

In addition, psychiatrists may become involved in several situations. First, the psychiatrist may determine that one of his patients should be admitted or committed to a short-term care facility, psychiatric facility, or special psychiatric hospital. Second, the psychiatrist may become involved as a result of the screening service's request that the psychiatrist sign a screening certificate certifying that the individual is in need of psychiatric commitment/admission. Third, the psychiatrist's involvement may be directly related to his affiliation with a short-term care facility, psychiatric facility, or special psychiatric hospital in which the psychiatrist is a member of the individual's treating team. In any of these events, the psychiatrist may be asked to testify in a court hearing in which the court will determine whether initial or continued commitment is appropriate.

This new law will have a broad impact on the process of psychiatric commitment in New Jersey. It will require more involvement from the psychiatric health care community.

This new law is expected to cost more money than currently is being spent in this area. The statute provides: "Any costs incurred to comply with the provisions of this act will be considered allowable in establishment of rates, which are to be set in a regulatory environment." (Section 31)

The statute also provides an appropriation of

COVER STORY

\$100,000 from the general fund to the Department of Human Services. This appropriation is for the purpose of "develop[ing] training procedures for law enforcement personnel and additional outreach and psychiatric services." (Section 32) Will these financing provisions provide the necessary funds for this new law? Will the money come from state government or county government, or some combination of the two governments?

Are there adequate mental health facilities in ex-

istence to implement the provisions of this new law? The legislation states that counties are encouraged to develop "short-term care facilities to enable a mentally ill person to receive acute, inpatient care in a facility near the person's community." (Section 1(d)) How will this be accomplished and who will pay for it?

Two things are clear: This new law will affect all physicians, nurses, and mental health professionals in the state of New Jersey and November 7, 1988, will be upon us all too soon. Are we ready?

Procedure for Commitment

Evaluation by Screening Service?

Yes

No

Involuntary commitment necessary?

Yes

No

Screening certificate
(signed by screening
service and psychiatrist)

Transportation and admission to
appropriate facility

Can hold for 72 hours
while seeking court order
for involuntary commitment

Submit to court: screening
certificate and clinical certificate
from member of treating team
at facility

Probable cause for court
to believe involuntary commitment
necessary?

Yes

No

Court orders
involuntary
commitment
pending final
hearing

Court orders discharge

Referral to appropriate
community health or
social services agency
or appropriate professional
for inpatient care in
psychiatric unit of
general hospital

No involuntary commitment
until court issues temporary
court order based on
two clinical certificates, at
least one signed by psychiatrist

Probable cause for court
to believe involuntary
commitment necessary?

Yes

No

Temporary
court order to
commit to
facility pending
final hearing

Cannot
involuntarily
commit

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Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy with nizatidine.

Drug Interactions—No interactions have been observed between Axid and theophylline, chlorazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice; although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement

compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 300 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 500 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use—Safety and effectiveness in children have not been established. Use in Elderly Patients—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events were also reported; it was not possible to

determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H₂-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. **Integumental**—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD₅₀ values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively. PV 2091 AMP [041288]

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STEROID DANGER IN KEARNS-SAYRE SYNDROME (KSS)

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KSS is caused by a defect in mitochondrial oxidative phosphorylation which inhibits synthesis of adenosine triphosphate and impairs oxidative metabolism. A steroid-induced glucose load exacerbates this, and a severe metabolic derangement with high mortality can result.

Kearns-Sayre syndrome (KSS), an important although rare mitochondrial disease, can cause unpredictable sudden death, including death with the use of steroids. In its fully developed state, KSS consists of progressive external ophthalmoplegia, pigmentary retinopathy, and heart block. These and other associated abnormalities are described as an aid to diagnosis so that therapy may be begun early, and treatment with steroids avoided.

CASE PRESENTATION

The patient, an 18-year-old white male, was the product of a 37-week gestation, during which time his mother had self-controlled bleeding in the first trimester. He had a breech delivery aided by forceps. During early childhood, he experienced no unusual illnesses. Since age 2 years, he has been below the 25th percentile for height and weight (Figure 1). A maternal half-brother is short of stature, and there is a diabetic history in a paternal half-sister and the maternal grandfather.

At age 6, he developed a mild, intermittent drooping of his left upper lid, and over the next two years his right upper lid became similarly affected. Eye muscle movements and retinal examinations were normal. During this time, it was determined that he had a learning disorder.

Mild hearing loss was noted at age eight, and a 1+ proteinuria was found. There were no other renal findings. At age nine, excessive fatigue was noted on mild exertion along with weakness of his limb muscles, but tests for myasthenia gravis were negative. An electrocardiogram showed a mild conduction defect with a short PR interval. Serum lactate was 24.1 mg/dL (n=8.0-20.0 mg/dL) and pyruvate was 1.45 mg/dL (n=less than 1.10 mg/dL). A fine pigment granularity was noted in the macula of each eye.

At age 10, mild limitations of upward and lateral gaze were noted, the ptosis and retinal pigment changes remaining mild; vision was correctable to 20/20 in each eye. His proteinuria had increased to 2+. At age 12, a Wolff-Parkinson-White syndrome, type A, was diagnosed. The cardiac evaluation, including an echocardiogram, revealed no other abnormalities. Blood sugar was normal; proteinuria remained at 2+. Renal studies, including an intravenous pyelogram, were normal.

At age 14, proteinuria increased to 3+; he was re-

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ferred to the nephrology division of a university hospital, but no treatment was prescribed. A neurosensory hearing loss was recognized. From age 14 on, there was a worsening of the ptosis, along with a further weakening of the extraocular, facial, and limb muscles. There was an increase in the retinal pigment dispersion along with the onset of night vision difficulties. A renal biopsy at age 16 was interpreted as either idiopathic focal segmental glomerulosclerosis or glomerulosclerosis due to arterionephrosclerosis. Intermittent blood pressure elevations also were noted.

At age 17, because of the longstanding nephrotic picture, his nephrologist prescribed prednisone, 20 mg three times a day for one month, to be tapered by alternate day dosage for one month, with weekly observations of his blood pressure and proteinuria.

After the sixth week of treatment and approximately 24 hours after taking his last dose of steroid, the patient had three generalized convulsions. He had just consumed a quantity of "cola." He was taken to a local hospital, where he suffered two similar seizures. He was somnolent, and laboratory findings showed a blood sugar of 954 mg/dL, pH of 7.33 ($n=7.35-7.45$), Na 130 mEq/L, K 4.1 mEq/L, and urine sugar 3+, protein 1+, and ketones 1+. There was no past history of convulsions or diabetes. He was given insulin, intravenous fluid, valium, and dilantin. Subsequently, he was transferred to a university hospital in a somnolent state. He was noted to have a Cushingoid appearance. Ongoing treatment had produced the following results: blood sugar 123 mg/dL, pH 7.43, Na 147 mEq/L, K 3.7 mEq/L, Cl 110 mEq/L, CO_2 24 mEq/L, pCO_2 44 mmHg, and pO_2 70 mmHg. Urinalysis showed sugar 3+, protein 1+, ketones 1+, WBC 5-10/HPF, and RBC 20-50/HPF. Blood pressure was 130/86, pulse 114, temperature 100.2° F, and respiration 16/minute.

Rehydration was continued, along with the administration of insulin and dilantin, and he rapidly recovered. A contrast-enhanced computed tomography (CT) scan and an MRI were normal. EEG was abnormal, with multiple, paroxysmal bursts of high amplitude delta waves in the frontal and central regions. Cerebrospinal fluid findings were normal. Biopsy of the quadriceps muscle showed abnormal clusters of mitochondria. A pediatric nephrologist observed that his proteinuria of 1.2 g/day had changed little as the result of six weeks of steroids.

After one week, he was discharged on dilantin and insulin, which were stopped shortly after his return home, and, over the past year, he has had no convulsions and his blood sugar has remained normal. Recently, due to the severity of the ptosis and an almost complete paralysis of upward and lateral gaze, conservative ptosis surgery was performed on each upper lid which he tolerated well. The tissue obtained was insufficient for microscopic and biochemical studies. His vision was correctable to 20/30 in each eye, and he has since returned to his usual activities.

KEARNS-SAYRE SYNDROME

In 1958, Kearns and Sayre reported the association of progressive external ophthalmoplegia, pigmentary retinopathy, and heart block. Studies have shown Kearns-Sayre syndrome (KSS) to be a rare, multi-system, mitochondrial disease characterized by spo-

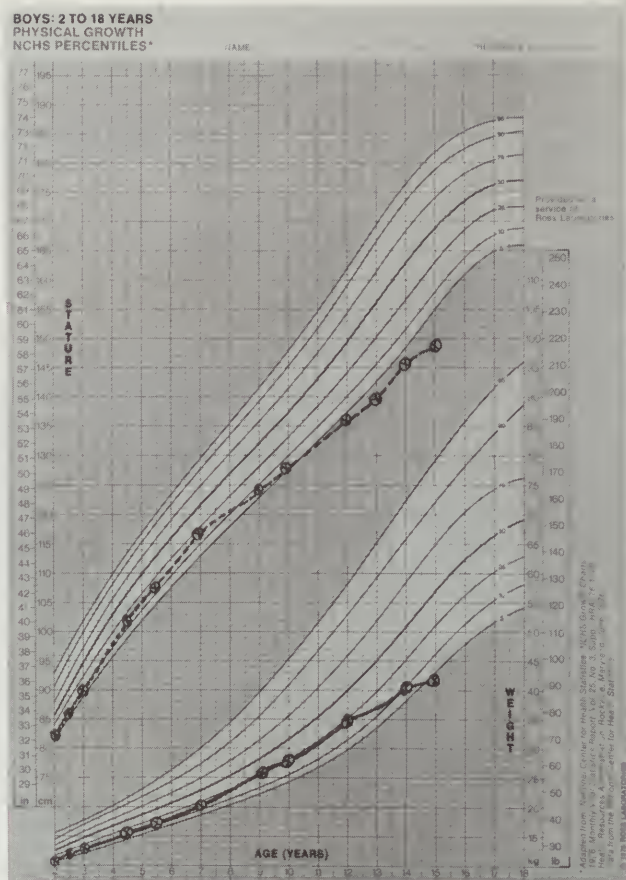


Figure 1—Physical growth chart for boys, ages 2 to 18 from the National Center for Health Statistics.

radic occurrence, progression, and sudden death. Its onset usually is under the age of 20, and it is ushered in by ptosis or extraocular muscle pareses, both of which are progressive. Diplopia is an uncommon complaint, and the ophthalmoplegia appears troublesome only when it becomes total.¹⁻¹⁰

A pigmentary type of retinopathy occurs but may be delayed by years. It differs from retinitis pigmentosa by showing a fine, "salt and pepper" dispersion of pigment, more central in location, and without associated vascular or optic nerve changes. Decreased acuity and night blindness can occur, but afferent pupillary defects and severe visual loss are seldom seen. The electroretinogram often is normal, and the retinal pathology usually has a mild, benign course. A breakdown in the energy relationship between the retinal pigment epithelium (RPE) and the photoreceptor layer appears responsible for these retinal changes.¹⁻¹⁰

Cardiac conduction defects occur in KSS, but heart block may not occur until months or years after other manifestations of the disease. These patients must be followed closely as cardiac arrest can occur abruptly. Treatment by pacemaking in some arrhythmias has improved the length and quality of life. Sudden death may occur from other manifestations of the disease, such as spongiform degeneration of the brain.^{3,11-17}

Since the original description by Kearns and Sayre, many associated findings have been reported. In the fully developed syndrome, Berenberg and coworkers noted: cerebellar signs (69 percent), short stature (63 percent), neurosensory hearing loss (54 percent), intellectual impairment (40 percent), vestibular system

dysfunction (33 percent), and delayed puberty (33 percent).³ Elevated serum lactate and pyruvate are a prominent part of the syndrome.^{15,18-20} Cerebrospinal fluid protein has been over 100 mg/dL in 80 percent of the cases and has been used to predict those patients most likely to develop the full syndrome.³ Among other findings are diabetes mellitus,²¹ hypoparathyroidism and intracranial calcifications,²²⁻²⁵ hypogonadism,²⁶ growth hormone deficiency,^{27,28} neuropathy,^{15,23} abnormalities on CT scanning,^{29,30} limb and cranial nerve weaknesses,³ abnormal electroencephalography (EEG),^{3,4,26} and Wolff-Parkinson-White syndrome (WPW).² In autopsied cases, spongiform degeneration of the brain is a constant finding and has been responsible for a wide range of neurological abnormalities, some of which lead to sudden death.^{3,14,31}

Electron microscopy of stained skeletal muscle reveals a characteristic pathology of type 1 fibers, which are rich in mitochondria and responsible for slow, sustained contraction. They are torn and show bright-red staining material. These "ragged-red fibers" derive most of their energy from mitochondrial oxidative phosphorylation (OXPHOS). By contrast, type 2 fibers, responsible for fast, short-duration contractions and dependent on glycolysis for energy, appear normal. "Ragged-red fibers" show highly altered and degenerated areas having coarse, clumped material; these contain abnormal clusters of distorted and swollen mitochondria. Inability to meet energy demand, resulting from impaired OXPHOS, causes these mitochondrial attempts at compensatory proliferation. This muscle picture is called "mitochondrial myopathy"; it should be noted, however, that "ragged-red fibers" and morphological alterations in mitochondria, even though a constant finding in KSS, are nonspecific and observed in a variety of muscle disorders.^{2-8,15,20,26,27,32-35}

OXPHOS

In KSS, there is a basic defect in OXPHOS, resulting in a decreased production of adenosine triphosphate (ATP) by the mitochondrion, along with an accumulation of hydrogen ions. Normal cellular activity depends on a steady supply of high energy phosphate from ATP, and its resynthesis from adenosine diphosphate (ADP) and phosphate must be rapid and efficient. Most of the energy required to accomplish this resynthesis is supplied by OXPHOS, which is controlled by nuclear and mitochondrial OXPHOS genes. During OXPHOS, a charge is given to the mitochondrial inner membrane by a complex process utilizing the controlled burning of hydrogen (from foodstuffs) with oxygen. This energy charge "drives" ATP synthase to condense ADP with phosphate to make ATP, and under aerobic conditions with unimpaired oxidative metabolism, hydrogen ions do not accumulate. An OXPHOS deficiency, however, reduces ATP resynthesis, impairing steady-state aerobic processes and recovery from oxygen debt; hydrogen ions accumulate and lead to lactic acidosis. Increased cellular energy demand exacerbates this. The ongoing OXPHOS deficiency causes progressive changes in all organ systems; those heavily dependent on OXPHOS are the most affected and include the brain, heart, kidney, liver, and type 1 skeletal muscle.²⁰

A less efficient pathway for ATP manufacture is anaerobic glycolysis, from which lactate and water re-

sult; but, lactic acidosis is unlikely if oxidative metabolism is unimpaired, since there is no net increase in the number of hydrogen ions. An OXPHOS defect or inadequate oxygen intake can alter this by causing hydrogen ions to accumulate; the resultant acidotic changes can have a profound effect on enzyme systems and tissue function.

NON-MENDELIAN MITOCHONDRIAL INHERITANCE

The etiology of the mitochondrial OXPHOS defect is unknown; but, heredity, slow virus, and autoimmune disease have been advanced as possible causes. A possible genetic factor must be considered. Genes are located on chromosome pairs in the nucleus and are contributed equally by each parent, except for one set that is located in the cytoplasm and inherited only from the mother. This set is found in the mitochondrion, a cytoplasmic organelle responsible for producing most of the ATP necessary to energize a human being. The mitochondrial genome (gene system) includes 13 OXPHOS genes, all vital to normal ATP production. Each of these genes has its own specific deoxyribonucleic acid (DNA) and genetic code, totally independent of nuclear genes, and without access to the mitotic spindle.^{3,20,36}

The sperm has little cytoplasm and few mitochondria, and does not contribute to mitochondrial inheritance. Through direct cytoplasmic continuity, only the mother transmits mitochondrial genes to the next generation. Mitochondrial DNA mutates much faster than nuclear DNA, and a sufficient distribution of mutant, maternal mitochondrial DNA can cause a phenotype change. Studies of families in which KSS has appeared, along with studies of other mitochondrial diseases having some common features, bring up the possibility of a maternal, cytoplasmic DNA transmission; if KSS is hereditary, its apparent departure from Mendelian principles would tend to place the defect in the mitochondrial, not the nuclear, OXPHOS genes.^{20,36}

ALTERED CARBOHYDRATE METABOLISM

An ATP deficiency, resulting from a mitochondrial OXPHOS defect, impairs cellular oxidative processes and alters carbohydrate metabolism with lactate and pyruvate accumulating; indeed, lactate and pyruvate are seen to soar after glucose-loading or exercise at any stage of KSS. The imbalance between ATP synthesis and hydrolysis results in an excess of hydrogen ions, which dissipate by converting lactate to lactic acid. Increased energy demand accelerates this, and hyperglycemia, such as that induced by steroids, causes lactic acid to accumulate (Figure 2). During periods of increased physical activity, lactic acid accumulation in skeletal muscle is severely exacerbated due to the weakness of a defective OXPHOS system in trying to help meet the metabolic demand for increased oxygenation.^{15,37,38}

A pancreatic OXPHOS deficiency compromises insulin production, and the stressing of this pathway causes a diabetic picture. Such stress occurs with glucose accumulation, which can be steroid-induced (Figure 2). Steroids also have a direct inhibitory effect on insulin effectiveness; this impedes peripheral utilization of glucose and intensifies existing diabetes.

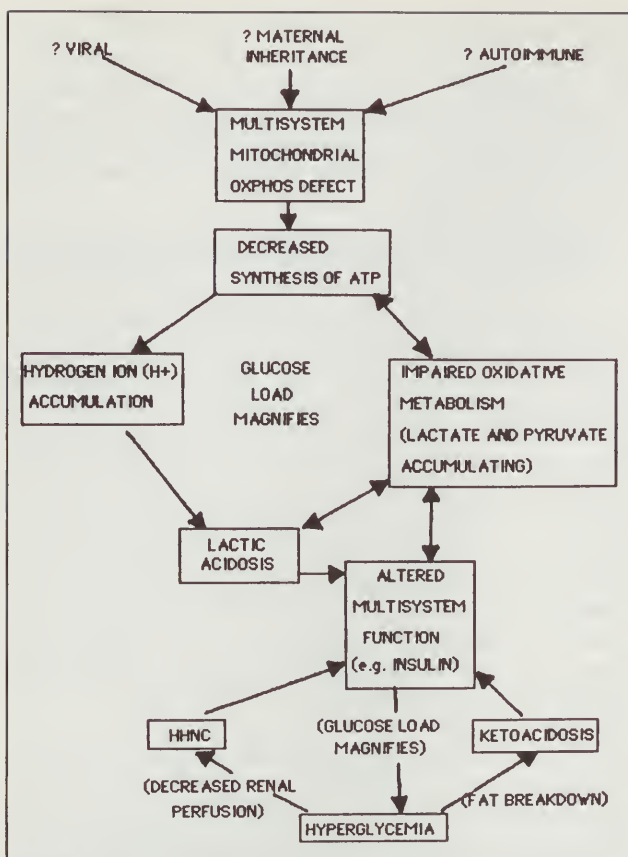


Figure 2—Tracking diagram of Kearns-Sayre syndrome.

With unimpaired insulin production, however, it is unusual for steroids to cause more than a slight blood sugar rise.

Biochemical analysis of mitochondria in skeletal muscle suggests that the OXPHOS deficiency may be due to a defect in NADH dehydrogenase (complex 1)^{18,20} and Ogasahara and coworkers³⁷ have reported prevention of the lactate-pyruvate rise by the use of coenzyme Q₁₀. Low folate levels seen in KSS also may play a role, and treatment with folic acid has been suggested.^{39,40}

HYPEROSMOLAR, HYPERGLYCEMIC, NONKETOTIC COMA (HHNC)

If excess water loss and decreased renal perfusion accompany hyperglycemia, there can occur a syndrome characterized by: serum hyperosmolality of over 340 mOsm/L; variable neurological signs, including depressed sensorium, seizures, and frank coma; hyperglycemia of over 541 mg/dL with minimal ketosis; severe dehydration; and high mortality. This is called hyperosmolar, hyperglycemic, nonketotic coma (HHNC) and most commonly is seen in older diabetics with renal disease.⁴¹⁻⁴³

KSS patients treated with steroids appear to be prone to HHNC with OXPHOS defects in the pancreas and kidneys, and possibly the adrenals, playing major roles. The sequence may be explained as follows: a steroid-induced glucose load cannot be disposed of, and hyperglycemia causes glucosuria with an osmotic diuresis. Renal disease and adrenal insufficiency can contribute. The resultant blood volume deficiency shows a water deficit that is initially greater than that of electrolytes, causing an extracellular hyperosmolali-

ty. This results in an impaired sensorium, interfering with the patient's urge for fluid replacement. Decreased renal perfusion takes over the dominant role, and increasing hyperosmolality, hyperglycemia, and dehydration can rapidly lead to coma (Figure 2). Insulin levels at this stage usually are marginally sufficient to support energy needs, so the body does not have to turn appreciably to fat stores whose excessive breakdown would cause severe ketosis. The insulin therapy needed by surviving patients appears to be unchanged from that required before the HHNC. Lactic acid accumulation in KSS is exacerbated in HHNC due to an impaired cellular oxidative response to hyperglycemia. Flynn and coworkers reported two cases of hyperosmolar, hyperglycemic, lacticidotic coma, and death in KSS patients treated with steroids for muscle weakness.^{15,41-44}

DISCUSSION

This case emphasizes the danger of steroid therapy in KSS. Steroids were given to treat a longstanding nephrotic syndrome. The resultant glucose load, however, triggered a series of events: increased cellular energy demand caused an acidotic state because of added stress on a defective OXPHOS system, further impairing ATP synthesis and oxidative metabolism; a pancreatic OXPHOS defect compromised the insulin response and caused hyperglycemia; and reduced blood volume with decreased renal perfusion resulted, causing hyperosmolar, hyperglycemic, nonketotic coma (HHNC). This possibly was accelerated by an OXPHOS defect in the kidneys and a steroid effect on the adrenals. Increased carbohydrate intake in the form of "cola" exacerbated these events.

Fortunately, the patient's metabolic derangement was diagnosed and treated before an irreversible state appeared. Rehydration and normal electrolyte balance were carefully achieved. Blood glucose was normalized promptly, alleviating hyperglycemic stress and preventing severe acidosis. Mild acidosis readily responded to treatment, and brain dysfunction, as manifest by somnolence, convulsions, and abnormal electroencephalography, did not result in permanent, detectable consequences. Even though treating hospital physicians concurred with the diagnosis of KSS, serum lactate and pyruvate were not obtained. Upon recovery, the patient's OXPHOS system appeared sufficient to maintain a relatively normal, though tenuous, carbohydrate metabolism without the need for insulin. Subsequent anticonvulsant therapy was not required.

The steroid-induced changes that occur in KSS patients who have significant pancreatic involvement are interrelated: with HHNC, ketoacids are moderately elevated; with diabetic ketoacidosis, there is a degree of hyperosmolality; and, with a compromised OXPHOS system, lactic acidosis plays an early, prominent role, being exacerbated by hyperglycemia and HHNC (Figure 2). These result in a further weakening of enzyme systems and metabolic processes.

Some progress has been made in the treatment of these energy-compromised people; cardiac pacemaking in certain arrhythmias has improved the length and quality of life; metabolic imbalances and endocrine deficiencies have been helped; and, ptosis surgery in selected cases has improved vision, head posture, and

cosmesis. Coenzyme Q₁₀ has been reported to improve both cardiac function and carbohydrate metabolism, and the use of folic acid also has been advocated. Carbohydrate restriction and steroid avoidance appear to be essential. It is in the central nervous system, however, where the most ominous features of the disease exist, as these are disabling, progressive, life-threatening, and untreatable. Muscle weakness also appears to be refractory to treatment at this time.

Many abnormalities eventually are seen in KSS, but any treatment undertaken must be done with great caution in order to minimize stress to a defective OXPHOS system. Above all, physicians must be alert to the danger of giving steroids to KSS patients and aware of the need to maintain close cardiac supervision. In the developing syndrome, usually beginning in early childhood, the initial signs may be subtle, and the diagnosis can be missed. It should, however, be kept in mind whenever steroids cause a severe, unexpected disturbance in carbohydrate metabolism.

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CASE REPORT: THYROXINE OVERDOSE CAUSED BY A SUICIDE ATTEMPT IN AN ADULT

T. STURGIS, M.D., R.L. ROSENBAUM, M.D., H. GERHARD, M.D., SUMMIT*

The authors describe a case of massive thyroid hormone ingestion. They achieved a benign outcome with the use of beta blockers, barbiturates, and iodinated radiographic contrast material. Use of thyroid medication in depressed patients without clinical thyroid disease involves risk.

Thyroid hormone traditionally has been used to treat hypothyroidism and to suppress benign and malignant thyroid neoplasms. Recently, the use of thyroid hormone has been advocated for other conditions such as depression and premenstrual syndrome. The authors describe a depressed patient without known pre-existing clinical thyroid disease who took a massive dose of thyroid hormone in an attempt to commit suicide.

CASE REPORT

A 36-year-old woman with a history of severe depression was given 100 tablets of l-thyroxine 0.025 mg for unclear reasons. No other medication was prescribed. Twenty-four hours later, on New Year's Day, she swallowed the entire contents of the unused bottle. Ipecac and charcoal were administered, and minimal retained contents were obtained with gastric lavage.

The patient was admitted to the intensive care unit. She remained awake, but was agitated and depressed. Initial examination revealed blood pressure 134/90, pulse 107, warm and moist hands with fine tremor, and brisk reflexes. The thyroid gland was not enlarged.

She was treated with propranolol 20 to 40 mg by mouth every 4 hours to maintain pulse at 80/min or less. Phenobarbital, 30 to 60 mg every 6 hours, was given for agitation and detoxification, and 500 mg of

sodium ipodate (Oragrafin Sodium®) was added by mouth every 12 hours to inhibit peripheral conversion of thyroid hormone (T_4 to T_3).

Initial (and peak) thyroid hormone values obtained on admission were as follows: T_4 (thyroxine) 25.0 mcg/ml (normal 5.0-12.0), T_3 (triiodothyronine) uptake 46 (normal 30-40), free T_4 Index 7.7 (normal 1.0-3.2), T_3 RIA (triiodothyronine by radioimmunoassay) 490.0 ng/dl (normal 80-200), and TSH (thyroid-stimulating hormone) 2.7 mIU/ml (normal less than 10.0).

Clinical hyperthyroidism resolved within 72 hours, and the patient had a benign course with respect to her physical status. Serum T_3 RIA normalized on the third hospital day, and serum T_4 did likewise on the seventh hospital day, at which point antithyroid medication was tapered and discontinued (Table). The patient was transferred to the psychiatric service, and was not resumed on l-thyroxine.

DISCUSSION

The serum half-life ($t_{1/2}$) of T_4 is between six to eight days, whereas the $t_{1/2}$ of T_3 is approximately one to one-and-one-half days.¹ However, serum levels of T_3 can

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TABLE
Thyroid Function Tests after Acute
Ingestion of L-thyroxine

	T ₄	T ₃ Uptake	Calculated T ₄ Index	T ₃ RIA
Reference	5.0-	30-	1.0-	80.0-
Range:	12.0	40	3.2	200.0
Units	mcg/ml	%		ng/dl
Day 1	25.0	46	7.7	490.0
2	19.2	42	5.4	367.0
3	16.8	39	4.4	149.0
4	14.2	40	3.8	136.0
5	13.9	39	3.6	86.0
7	11.0	53	3.9	78.0
9	10.5	37	2.6	

remain elevated due to ongoing peripheral conversion of T₄ to T₃, as would be expected in a bolus administration of thyroxine, such as occurred in this case. The Table outlines the net effects of these factors.

Serum T₄ levels, serum T₃ levels, and the T₃ resin uptake are shown in the Table.¹ Although confirmatory, the T₃ resin uptake reflects binding globulin status, and by itself is not diagnostic of primary thyroidal dysfunction. The calculated free T₄ index will adjust total serum T₄ concentration for changes in binding, and, therefore, is a better parameter of free T₄ hormone levels and thyroid function.

A variety of pharmacological measures can be used to lower thyroid hormone levels, either by inhibiting peripheral conversion or by increasing hormone clearance. The drugs used in the management of this case have an additive effect in restoring the euthyroid state.

Propanolol has a beneficial antiadrenergic effect on tremulousness and tachycardia, has an antihypertensive effect, and inhibits peripheral conversion of T₄ to T₃. Phenobarbital enhances hepatocellular binding of thyroid hormone, and thus increases thyroxine turnover and clearance.²

More recently, sodium ipodate (Oraqrafin Sodium[®]) and oral cholecystographic agent have been advocated for use in hyperthyroidism.³ Iodate has been shown to be one of the most potent inhibitors of thyroxine (T₄) peripheral conversion to triiodothyronine (T₃) with minimal toxicity. In selected cases, combined use of these agents may obviate the need for steroids.

The total amount of thyroid hormone consumed in this case was approximately 2500 micrograms. Although quite excessive,^{4,5} it is of the same order as recently reported in an outbreak of thyrotoxicosis factitia.⁶

Most cases of massive thyroid ingestion reported in the literature describe pediatric patients, several of whom had adverse sequelae including arrhythmias, seizures, and tremulousness.^{7,9} As this case confirms, benign outcomes have been reported.¹⁰

We have seen thyroid hormone being used with increased frequency for a variety of conditions other than hypothyroidism or goiter. This case points out the potential for abuse, and we recommend that thyroid hormone be used only where documented thyroid disease is present.¹¹

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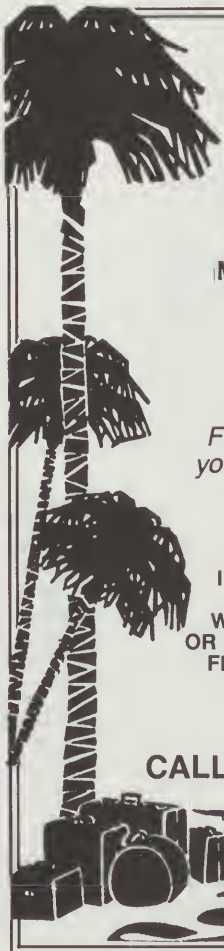
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REVIEW ARTICLE: BIOLOGICAL ACTIVITIES OF CHLOROPHYLL DERIVATIVES

SIMON A. CHERNOMORSKY, PH.D., AND ALVIN B. SEGELMAN, PH.D., PISCATAWAY*

The authors review the anti-inflammatory, wound healing, and malodor-reducing properties of chlorophyllin, a chlorophyll-related medicinal agent; the study includes plant-derived, chlorophyll-based compounds under study as useful anticancer, antiatherosclerosis, and antipsoriasis drugs.

Although chlorophyll generally is known as the major photosynthetic porphyrin pigment in plants, some of its chemical derivatives exhibit interesting biological activities in animals and humans. It has been at least 14 years since the last survey on this subject appeared.¹ The purpose of this article is to present a brief review of the older literature, the more recent publications, and some unpublished results of our ongoing studies. Selected aspects of the biological activities of chlorophyll derivatives, especially chlorophyllin copper complex (CCC), a centrally coordinated metal tetrapyrrole compound, with particular emphasis on stimulation of cell regeneration, influence on wound-healing retardation factors, toxicological characteristics, and the clinical application of CCC as a wound healing and deodorizing agent will be discussed. Furthermore, the possible utilization of these substances as therapeutic agents in some new, promising areas, also will be described.

PRECLINICAL STUDIES

Smith and Sano were among the first workers to investigate the effects of chlorophyll derivatives on cell growth using tissue culture methods.² The addition of 0.05 or 0.5 percent of CCC to cultured embryonic mouse heart fibroblasts resulted in a rapidly increased growth rate (40 percent) which was maintained by

replenishing the CCC every 48 hours. Another tissue culture study demonstrated similar growth stimulating effects of chlorophyll derivatives. For example, these substances at concentrations of $2 \times 10^{-4} \text{M}$ increased by 31 percent the neurite outgrowth in mouse neuroblastoma cells.³

The observations made on the tissue culture studies also were investigated in animal experiments. Ointments containing chlorophyll derivatives which were applied to guinea pigs and rabbits with induced skin wounds resulted in faster healing rates than those occurring with some other agents tested. "Chlorophyll" therapy initiated early appearance of clean granulation tissue, rapid epithelization, and acceleration of wound healing without inflammation.⁴ Similar studies in various animals showed that CCC consistently displayed statistically significant effects, increasing the rate of healing by approximately 25 percent in about 68 percent of the cases of traumatic and thermal wounds.⁵ Additional experiments using topical "chlorophyll" therapy supported the positive wound healing effects noted earlier.⁶ Chlorophyll derivatives

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led to activation of fibroblasts, reduction of epithelialization time, and marked increases in cell mitotic indices which accompanied accelerated wound healing. Also, it was observed that the number of blood vessels and the resultant circulation in the chlorophyll-treated wounds were increased.^{7,8}

In connection with wound healing, one of the concerns among clinicians is the recognition that topical wounds and ulcers frequently are infected. Thus, even when treated by preparations which stimulate cell regeneration, infected areas heal poorly. Clearly, an ideal wound-healing agent should demonstrate dual actions: cell regeneration as well as antimicrobial properties. In a series of further investigations, it was shown that CCC⁹⁻¹¹ and other chlorophyll derivatives^{12,13} were bacteriostatic in vitro, mainly against gram-positive microorganisms, some of which are wound pathogens. Also, these substances neutralized *Staphylococcus aureus* and *Clostridium perfringens* toxins¹⁴ which may inhibit or prevent wound healing. The topical application of CCC abolished the undesirable hemagglutinating and inflammatory effects of one or more components of microbial and non-microbial origin present in wound exudates and thereby promoted healing.¹⁵ Finally, CCC inhibited staphylococcal coagulase-induced clotting that otherwise may result in fibrin-coated bacteria which subsequently resist phagocytosis.¹⁶

Another approach taken for studying the cell regeneration activity of chlorophyll derivatives was to study the effect of these substances on formed blood elements. The administration of these agents alone or with iron-containing compounds, stimulated the production of hemoglobin and erythrocytes in anemic animals.¹⁷ Anemic rabbits fed a regular diet supplemented with chlorophyll derivatives recovered after 14 days, compared to 23 days for the controls.¹⁸ Other studies in anemic animals treated with CCC (0.025 g/kg, intravenous or 0.05 g/kg, by mouth)¹⁹ or with different chlorophyll derivatives (0.05 mg/kg, subcutaneously)²⁰ showed a 70.5 to 83 percent increase in erythrocytes and normalization of hemoglobin levels in 10 to 16 days. Oil-soluble as well as water-soluble chlorophyll derivatives exhibited antianemic effects.²¹ Chlorophyll-iron complexes have been especially successful in managing anemic animals.²² The utility of chlorophyll derivatives for treating various anemias also was described by other workers,²³ although it should be noted that in one study, these substances were ineffective.²⁴ In addition to erythrocytes, the regeneration of other blood cells can be stimulated by these substances. Thus, chlorophyll derivatives administered intraperitoneally reversed or prevented chemical and x-ray-induced leukopenia in several animal models.^{25,26}

Moreover, the regenerative and protective properties of chlorophyll derivatives were further substantiated by observing the effect of these substances on some internal organs. Thus, orally administered CCC-containing preparations showed antiulcer activities in animals.²⁷ Also, chlorophyll derivatives protected against carbon tetrachloride-induced liver damage in animals.²⁸ Finally, in in vivo models, these agents increased oxygen consumption, which is an indicator of cell regeneration.²⁹

The potential of chlorophyll derivatives, particularly CCC, for therapeutic use, initiated toxicological studies on the latter. Thus, rabbits, dogs, cats, guinea pigs, rats, and mice were administered CCC by various routes. The doses, ranging from 100 to 300 mg daily, were given for periods of from five to eight days depending on the animal. At all of the doses administered, no animals were found to exhibit signs of toxicity, thereby attesting to the safety of CCC.³⁰ In mice the LD₅₀ (lethal dose) values for CCC were: 285 mg/kg intravenously, 400 mg/kg intraperitoneally (ip), and 10 g/kg by mouth.³¹ Harrison and colleagues using Swiss male mice reported the following acute toxicity data: LD₅₀, 7 g/kg by mouth (LD₀, 5 g/kg and LD₁₀₀, 12 g/kg) and 0.19 g/kg ip (LD₀, 0.13 g/kg and LD₁₀₀, 0.32 g/kg).³² Moreover, during a ten-day period, Sprague-Dawley rats ingested a total of 10.2 g and 13.4 g of CCC, respectively, with no deaths observed (LD₀, 50 g/kg). These results point up the fact that CCC is an extremely safe substance from an acute and chronic toxicity point of view.

CLINICAL STUDIES

Wound healing. The cell regeneration effects of CCC in tissue culture and animal model studies, its influence on wound healing retardation factors, and its apparent lack of toxic properties led to clinical investigations which started actively in the United States in 1940. Ointments and solutions containing chlorophyll derivatives, including CCC*, were found to promote wound healing and to reduce malodors in various types of suppurative lesions.³³ In more than 400 hospital cases of suppurative disease, the topical application of CCC stimulated granulation tissue and epithelization better than several other agents.³⁴ Numerous clinical cases of chronic, refractory skin lesions, mainly dermal ulcers which failed to respond to conventional therapy, were treated successfully with CCC.³⁵ Marked improvement and healing following CCC therapy, with relief of itching and burning, were reported in various types of dermatological cases as well as in burns.^{36,37} Indeed, numerous clinical studies have demonstrated the potential of CCC as a tissue stimulant and wound healing agent in managing a wide variety of burns, dermatoses, and skin and gingival lesions.³⁸⁻⁴² Objective methods to evaluate the effectiveness of CCC using comparative therapy with other agents in patients with bilateral lesions demonstrated CCC to be the wound-healing drug of choice.⁴³ Only a few reports have failed to show a therapeutic effect for CCC in the wound-healing process,⁴⁴ with one study indicating that CCC at least tended to improve wound appearance.⁴⁵

Although CCC topical therapy generally gave acceptable clinical results, continued experience with CCC preparations revealed that some cases of especially chronic, slow-healing ulcers failed to respond satisfactorily.³³⁻⁴⁵ Further investigations showed that these recalcitrant lesions exhibited decreased vascularization due to capillary occlusion by agglutinated erythrocytes. In addition, the occurrence of densely collagenized

*Most of the clinical studies in the United States employed ointments containing 0.5 percent CCC in a water-washable base or aqueous solutions containing 0.2 percent CCC (Chloresium®, Rystan Co., Inc.)

fibrous tissue, together with toxic products from tissue breakdown and necrosis within the ulcer itself, led to incomplete healing with frequent reoccurrences of healed tissue breakdown.⁴⁶ Therefore, a novel topical preparation* was developed which contained CCC as an antiagglutinating and wound-healing agent, the proteolytic enzyme papain as a debriding agent, and urea to render necrotic tissue and wound debris more susceptible to papain breakdown. This formulation was more effective (86 percent complete healing) than either papain or CCC alone in treating slow-healing wounds.⁴⁶ Twenty-three of 24 patients⁴⁷ and 26 of 27 cases,⁴⁸ all involving various foul-smelling skin ulcers and suppurative wounds, were effectively managed and, in many cases, completely healed⁴⁷ with the papain-urea-CCC(PUC) ointment. Different types of chronically infected wounds, many of which did not respond to antimicrobial therapy, and/or surgical debridement were effectively treated with PUC therapy.^{49,50} Eradication of local infection and complete healing of chronic dermal ulcers were reported in 36 of 37 cases.⁴⁹ Application of PUC ointment in 18 of 22 cases of chronically infected wounds provided effective debridement prior to surgery, eliminated malodors, and avoided surgery in a few cases.⁵⁰ All these clinical reports indicated that the use of PUC ointment was safe, i.e. transient; mild local effects including burning, stinging, or itching were only rarely observed and generally did not warrant cessation of therapy, and were highly beneficial in managing slow-healing wounds complicated by necrosis and infection.

Internal Deodorization. In view of the many observations that CCC exhibited deodorizing effects as well as healed foul-smelling wounds, it was suggested that CCC might be helpful in controlling the odor problems of ostomy patients. Early reports showed that the deep insertion of chlorophyll derivatives by patients into their colostomies led to significant deodorization.⁵¹ Subsequently, it was shown in several studies that the oral administration of CCC** in doses of about 100 to 200 mg daily to colostomy patients, was sufficient to control malodors without undesirable side effects.⁵²⁻⁵⁴ Using the same dosage schedule, many studies also have been carried out on the use of CCC to control malodors in patients with urinary and fecal incontinence problems.⁵⁵⁻⁵⁸ Except for one study which employed low, daily oral doses of CCC over relatively short periods of time,⁵⁸ these reports generally afforded evidence that odors were reduced markedly in about one week and continued treatment maintained good control consistently. CCC has been classified as being generally recognized as safe and effective as an internal deodorant by the U.S. Food and Drug Administration.⁵⁹

MODE OF ACTION

The exact mechanisms whereby chlorophyll derivatives promote wound healing are not fully understood. Some possibilities include: a) the stimulation of protein synthesis²⁰ in a manner similar to that known for

heme⁶⁰ and subsequent cell regeneration^{2,3,12} with concomitant increased oxygen uptake;²⁹ and b) antimicrobial effects and/or direct neutralizing effects on toxins as well as other wound-healing retarding compounds present in wound exudates.^{9-16, 61-68} Various mechanisms have been suggested to explain the deodorizing effect of chlorophyll derivatives. Thus, the absorptive properties of these substances for odorous compounds have been reported.⁶⁴ Chlorophyll derivatives were found to tightly bind and immobilize odorous microbial indolic compounds.⁶⁵ Also, these chlorophyll derivatives may induce metabolic changes in odor-causing microorganisms. For example, *P. vulgaris* grown in the presence of these agents produced lesser than normal amounts of hydrogen sulfide, ammonia, and methyl indole compounds.^{66,67} It is tempting to speculate that at least one common general underlying molecular mechanism may account for the biological activities of chlorophyll derivatives. This mechanism may involve the affinity of these substances to form complexes with proteins. As a result, the normal biological activities of the complexed proteins are altered.

NEW AREAS OF APPLICATION

This review deals mainly with the use of chlorophyll derivatives as wound healing and deodorization agents. However, studies carried out in the last decade have suggested that new medical applications may be developed for these substances. For example, since several different enzymatic reactions were influenced by chlorophyll derivatives,^{68,69} these agents were evaluated for treating experimental pancreatitis^{70,71} which involves pathological changes induced by certain enzymes. The preclinical results were promising, and a few clinical studies have shown that chlorophyll derivatives may be useful in treating pancreatitis.⁷²

Of great interest are reported studies on the antimutagenic effects of chlorophyll derivatives and plant extracts rich in chlorophyll. These preparations have demonstrated most activity against several carcinogens in the Ames Salmonella/mammalian microsome test as well as in other test systems.^{73,74} If further investigations confirm that chlorophyll and its derivatives possess antimutagenic and/or anticancer properties, the inclusion of these agents in the human diet may provide a modicum of protection against cancer disease. Also, new attempts to investigate the action of chlorophyll derivatives on formed blood elements have been undertaken. Thus, orally administered, these substances were used successfully to increase the number of leukocytes in children suffering from leukopenia due to various causes. In some cases, these agents prevented leukopenia and, also, in combination with standard therapy, gave better results in treating thrombocytopenia of various origins than those obtained with the standard therapy alone.^{75,76}

A new technique, photodynamic therapy (PDT), was recently introduced to treat cancer disease. It includes the parenteral administration of selected photosensitizing porphyrins, for example, hematoporphyrin derivative (HPD), to patients, followed by the application of long wavelength light to the area of tumor growth. This procedure results in the generation of singlet oxygen in the photosensitized cancer cells and

*Ten percent papain, 10 percent urea, and 0.5 percent CCC in a water-washable base (Panafil® Ointment, Rystan Co., Inc.).

**Tablets containing 100 mg CCC (Derifil®, Rystan Co., Inc.).

subsequent photodestruction of tumors.⁷⁷ PDT also may be useful for treating psoriasis,⁷⁸ atherosclerosis,⁷⁹ and certain infections.⁸⁰ Preclinical PDT studies using different chlorophyll derivatives have shown that these substances are active antitumor photosensitizers^{81,82} and may prove to be better clinical candidates for PDT than HPD.

Chlorophyll derivatives also have been found to display immunological⁸³ and antioxidant⁸⁴ activities, but the practical application of these properties has not yet been developed.

CONCLUSIONS

Although one chlorophyll derivative, CCC, is enjoying an ever-increasing level of use as an internal deodorant, the wound-healing application of these substances, particularly to treat pressure sores and other skin ulcers, seems to have been neglected during the past 25 years. One possible explanation for this occurrence may be that much of the knowledge about the therapeutic applications of chlorophyll derivatives was forgotten because of the introduction in the 1960s of potent anti-inflammatory steroids and antimicrobial products intended for topical use (although steroids actually inhibit wound healing). Indeed, the management of patients with slow-healing wounds still presents problems today because the treatment is expensive and the rehabilitation time is prolonged.⁸⁵

Based on many published reports on the wound healing properties of CCC and other chlorophyll derivatives, as well as a consideration of the relatively low cost of these substances, it now would seem to be an opportune time to take a new clinical look at these neglected medicinal agents. Biological and chemical studies on chlorophyll derivatives, aimed at some of the new areas of applications (anticancer, antiatherosclerosis, and antipsoriasis), currently are underway in several laboratories worldwide. One can anticipate new and important results relative to this interesting group of natural substances.

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DOCTORS' BILL

The "collateral source" bill passed by the New Jersey Legislature and signed into law by Governor Kean is a significant victory in the Exchange's efforts to reform the medical malpractice legal system. The Exchange provided the leadership to give New Jersey physicians one of the strongest new laws of its kind in the nation. Elimination of some costly inequities in our tort system will help moderate the ever-increasing severity of insurance losses.

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Governor Thomas H. Kean (right) signs bill into law as New Jersey State Medical Underwriter, Inc. President Peter Sweetland (left) and Chairman Henry J. Mineur, M.D. (center) look on.

*Trustees' Minutes;
UMDNJ Notes;
AMNJ Report;
Pioneer Women
Physicians;
Physicians Seeking
Location in New Jersey*

Trustees' Minutes June 12, 1988

A regular meeting of the Board of Trustees was held on June 12, 1988, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Report of the President . . .

(1) Task Force on the Shortage of Nurses and Technical Personnel . . . Heard that a task force to address this problem is being appointed.

(2) Ad Hoc Committee on Graduates of Non-U.S. Medical Schools . . . Noted that Elmar G. Lutz, M.D., will serve as chairman of the Ad Hoc Committee on Graduates of Non-U.S. Medical Schools.

(3) Senior Medical Courtesy Programs . . . Requested reports on the status of county society participation in senior medical courtesy programs.

(4) Task Force on AIDS . . . Noted a meeting of the Task Force will be held on September 28, 1988, at MSNJ headquarters for all interested persons.

(5) Accountability of Claim Review Workers . . . Noted that a letter

was sent to the SBME indicating that the Society firmly believes third-party payors, when making determinations regarding the medical necessity of diagnostic tests, hospital admissions, and medical procedures, should be held accountable to the same standards as are treating physicians.

(6) Medical Inter-Insurance Exchange of New Jersey Workshop . . . Noted that Drs. Formica and Mineur are investigating the possibility of a weekend retreat to enlighten members of the Board, and presidents and presidents-elect of county and specialty societies about MIIENJ.

(7) Joint Executive Committee Meeting with NJHA . . . Noted that a joint meeting of the executive committees of MSNJ and NJHA will be on September 28, 1988.

(8) Ad Hoc Committee on Women in Medicine . . . Noted that Patricia G. Klein, M.D., will chair the Ad Hoc Committee on Women in Medicine.

Report of Executive Director . . .

(1) MSNJ Paid Membership . . . Noted that 7,156 members have paid 1988 dues.

(2) MSNJ Financial Statements . . . Reviewed and approved MSNJ's financial statements for the period ending April 30, 1988.

(3) Medical Discipline Matters . . . Heard that a legislative bill probably will be available toward the end of the summer on medical discipline.

(4) Legislative Matters . . . Noted the following positions on legislation: S-216—Chiropractic Board, opposition; S-734—Financial Disclosure, support; S-1208—Social Work, active opposition; A-470—DRG Study Commission, support; S-263—Statute of Limitations and S-1845—Structures in Payments in Tort Actions, active support; No-Fault, MSNJ is attempting to keep a fixed fee schedule out of any proposed legislation; and Reimbursement for Completion of Insurance Claim Forms, supported the suggestion that the Board direct a letter to the Departments of Insurance and Labor indicating that requests for medical reports are additional matters for which the physician is entitled to reasonable compensation.

Report of Legal Counsel . . .

(1) Resolution #7—Confidentiality of Medical Information; Resolution #8—Unauthorized Release of

Medical Information . . . Condensed both versions of these bills, as suggested by legal counsel, and directed that it be referred to the Judicial Council for review; revision version reads as follows:

Medical information should be considered a confidential communication between the patient and his physician. A patient's medical information should not be given to others without the expressed authorization of the patient, except for reports required by law, instances of medical emergencies, or when there is imminent danger to others. All physicians are advised that for medical-legal reasons, it is prudent to secure written documentation of the patient's authorization.

(2) Resolution #11—Telephone Information . . . Referred the following statement suggested by legal counsel to the Judicial Council:

Except when required by law, or in medical emergencies, or when there is imminent danger to others, it is unethical and improper for a physician to release patient information over the telephone to third parties unless the patient or his duly authorized representative has provided written consent to the release.

UMDNJ Report . . . Noted the following from Dr. Bergen's monthly report: more than 700 advanced degrees and certificates were conferred at the 15th annual commencement of UMDNJ; reviews of Robert Wood Johnson Medical School and New Jersey Medical School by the AMA have been completed successfully; salaries and benefits for nurses at University Hospital have increased recently in an effort to retain current staff and aid in the recruitment of new members; and an exhibit highlighting pioneer women in medicine is on display at the George F. Smith Library.

NJ Hospital Association . . . Noted the following from Mr. Scibetta's report: chairman of the NJHA Annual Meeting was Mr. Kenneth M. Coury, and Governor Kean was an honored guest; opposition by the Association to A-267—Pharmacy (prohibiting institutions from operating retail pharmacies within 1,500 feet of their facility) and support for A-472—Certificate of Need (CON) (provides exemption from CON requirements when a hospital and two or more physicians joint venture a project costing less than \$2 million); no physicians had been appointed

to the Hospital Association's Task Force on AIDS; and in the article in *New England Journal of Medicine* indicating that the mortality rate is measurably greater in states having higher levels of medical regulation, New Jersey was not included in the statistics.

Council on Public Health . . .

(1) Seminar on Counseling HIV Positive Patients . . . Approved and referred the following recommendation to the Task Force on AIDS for input and implementation:

That the Medical Society of New Jersey sponsor another educational seminar for physicians on AIDS, part of which is to specifically pertain to counseling patients who are HIV positive.

(2) Eye Health Screening Program . . . Approved the following recommendations:

That the Eye Health Screening Program be conducted only at hospital locations, mobile units operated by the New Jersey Commission for the Blind and Visually Impaired, and certain New Jersey Department of Health sites which will not benefit private entrepreneurs.

That the Eye Health Screening Program be medically oriented, and that it be conducted only by ophthalmologists.

Upcoming Events Regarding the National Study of Resource-Based Relative Value Scales for Physician Services . . . Received a report from the AMA on the resource-based relative value scale study.

AMA Response to the Nursing Shortage-Registered Care Technologists . . . Voted to refer the AMA report to MSNJ's Task Force on the Shortage of Nurses and Technical Personnel.

JEMPAC . . .

(1) Auxiliary Input . . . Noted Dr. Ryan's thanks to the Auxiliary for their help in defining the AMA position on certain aspects of the recently enacted Catastrophic Extension of Medicare.

(2) Board Meeting . . . Noted the next meeting will be on June 22, 1988; it is an open meeting.

Unfinished Business . . .

(1) Ex Officio Seat on Board of Trustees . . . Noted that the following recommendation was not adopted:

That the Speaker of the House of Delegates be given a nonvoting, ex-officio seat on the Board of Trustees.

New Business . . .

(1) Article in the Newark Star-Ledger . . . Noted that the president will respond to an article in the newspaper stating that "AIDS victims are not deserving of compassion because most are drug addicts and homosexual men."

(2) Medicare Disputes . . . Advised Dr. Barry R. Zitomer, president of the New Jersey Society of Internal Medicine that his concerns about Medicare should be addressed to the Council on Medical Services.

(3) Patient Lawsuits Publicized in Newspapers . . . Noted that there is little a physician can do about newspaper reports dealing with physicians being sued by patients.

(4) Selection Criteria for AMA Delegates and Alternates . . . Did not adopt the following recommendations proposed by Dr. Robinson:

That alternate delegates to the AMA should be actively practicing members of the Medical Society of New Jersey who are no older than 55 years of age when first elected to that post.

That delegates to the AMA should be actively practicing members of the Medical Society of New Jersey when first elected to that post; and that they not be eligible for re-election, if retired, unless they hold a chairmanship of a standing committee of the AMA, or have become an officer of the AMA.

Correspondence . . .

(1) Hospital Rates/Nursing Shortage . . . Noted the Hospital Rate-Setting Commission approved an 11.072 percent increase in reimbursement for labor costs; also, a 13-member Nursing Shortage Study Commission soon will make recommendations to meet the current nursing shortage crisis.

(2) Shortages: Nursing/Allied Health Technology . . . Noted MSNJ's letter regarding manpower shortage was referred to Dr. Molly Joel Coye; she is awaiting results of the Nursing Shortage Study Commission.

(3) State Board of Medical Examiners: Third-Party Payors . . . Noted a letter from Dr. Frank Malta, President of the SBME, advising that the final determination for the appropriateness of care is a physician, not a nonphysician reviewer.

UMDNJ Notes

**Stanley S. Bergen, Jr., M.D.
President**

For the second time in six months, the Center for Fertility and Reproductive Medicine at our Newark campus announced a breakthrough birth. This time the miracle resulted from a frozen embryo produced from a donated egg. It was the first known birth of its kind in the northeast United States and was among less than ten births worldwide.

Last March, University Hospital-based specialists announced the first known birth in the northeast of a baby conceived with a donor egg, a procedure that advanced yet another step of the use of the frozen embryo. In both cases, the women could not conceive due to premature ovarian failure.

In the recent case, the woman's sister donated several eggs which were fertilized in vitro with sperm from the woman's husband. An initial attempt at pregnancy failed, and the extra embryos were frozen for future use. It was a frozen embryo, thawed three months later and then implanted, that produced the new baby.

According to Center experts, this achievement with frozen embryos used techniques originally developed in the field of animal husbandry. At a certain stage of development—when the embryo either is one cell or has divided into two or four—it is dehydrated with the chemical cryoprotectant. The temperature then slowly is decreased to -190 degrees centigrade.

The embryo is placed in a thin, sealed cylinder that is stored in a container of liquid nitrogen. Then, to prepare for implanting, the embryo is thawed to room temperature and water is gradually added for rehydration. Unfertilized eggs cannot be frozen as they are too fragile to withstand the process.

Our Center has developed the combined use of two innovative procedures to retrieve eggs from the donor and to prepare the recipient to nurture a pregnancy. The program, which uses only volunteer donors who receive no payment, offers hope to women with ovarian failure or those born without ovaries.

Dr. Gerson Weiss, professor and chairman of the department and

an internationally renowned reproductive endocrinologist, assembled the team after he was recruited to the medical school two years ago as part of UMDNJ's plan to become one of the top 25 academic health centers in the country.

A model program for the evaluation, treatment, and prevention of child sexual abuse has been launched by UMDNJ's Robert Wood Johnson Medical School through a three-year, \$376,000 grant from the Robert Wood Johnson Foundation. Called "The Family Relations Project," it also is supported by the UMDNJ-Community Mental Health Center and the New Jersey Division of Youth and Family Services (DYFS), bringing total funding to approximately \$600,000.

The goal of the program, according to Dr. Raymond Rosen, professor of psychiatry, is to achieve a unified approach that brings together medical, social, and legal agencies to address the problem. The program is based at 85 Bayard Street in New Brunswick.

Child sexual abuse is not limited to any economic, racial, or ethnic group. The National Center for Child Abuse and Neglect estimates the incidence of child sexual abuse at 800 to 1,000 cases per million. A Canadian national survey showed that by the time a child reaches the age of 17, 9 percent of boys and 22 percent of girls have been the victim of a sexual assault. Between 15 and 18 percent of victims are five years old or younger. In 1985, 4,497 such cases were reported in New Jersey. But Dr. Rosen called that a serious underestimate because it is believed that victims reporting to authorities represent only 5 to 10 percent of the total number of cases.

Since the problem is viewed as many-sided, counseling is provided to all members of the family. Moreover, families will be followed for years in order to reduce recidivism rates.

Dr. Robert Johnson, director of adolescent medicine at the Newark-based New Jersey Medical School, has been appointed to the Governor's Council on the Prevention of Mental Retardation and Developmental Disabilities. The physician, a UMDNJ alumnus who has emerged as a national leader in the growing field of adolescent medicine, also was declared "citizen of the year" by

the New Jersey State Council of Black Social Workers.

John Kostis, M.D., chief of the Division of Cardiovascular Diseases at the Piscataway-based Robert Wood Johnson Medical School, has been named occupant of the Detwiler Chair in Cardiology at the New Brunswick-based school.

Joseph A. Liebermann III, M.D., professor and chairman of family medicine at the Robert Wood Johnson Medical School, is one of six recipients in the nation of a Robert Wood Johnson Health Policy Fellowship. The fellowship involves a one-year program of orientation and working experience in Washington, D.C. to teach leadership roles to faculty members.

AMNJ Report

Benjamin F. Rush, Jr., M.D.

The Academy of Medicine's Annual Awards Dinner held on May 25, 1988, at the Chanticleer in Short Hills was a major success. Approximately 260 guests gathered to honor our Award recipients and help install our new officers for 1988-1989.

Our Edward J. Ill award recipient, Dr. Richard C. Reynolds of Princeton and our Citizen's Award designee, Assembly Speaker Chuck Hardwick of Westfield were both eloquent in their responses. Dr. James S. Todd of Ridgewood, senior deputy executive vice-president of the AMA, was elected an Honorary Fellow of the Academy and became only the sixth such awardee in our history.

The Awards Committee, under the chairmanship of immediate past-president Tony Minnefor, presently is soliciting nominations for 1989. The deadline for receiving nominations has been moved to September 6, 1988.

New AMNJ officers for 1988-1989 elected at the Annual Awards Dinner were President, Benjamin F. Rush, Jr., M.D.; President-Elect, Frederick B. Cohen, M.D.; 1st Vice-President, Blackwell Sawyer, Jr., M.D.; 2nd Vice-President, George L. Triebnacher, M.D.; Secretary, Gerald Shapiro, M.D.; and Treasurer, Stanley Bresticker, M.D.

The Academy's staff is actively preparing the Annual Calendar for 1988-1989, which is our major CME publication. The calendar will include around 600 CME activities for

the forthcoming academic year and represents about half of the total number of programs we will sponsor and jointly sponsor for the year.

The calendar includes many other items of interest, including a list of available roving symposia topics, an application to participate in our Speakers Bureau, and a list of affiliated specialty societies and their presidents.

A multidisciplinary head and neck oncology section has been formed within the Academy. At an organizational meeting held on May 17, 1988, Dr. Harvey Yeager was elected chairman and Dr. Andrew Zablow was elected Secretary. The first scientific meeting of the group will be held on Thursday evening, September 15, 1988, at the Manor in West Orange.

The New Jersey Physicians Golf Association's summer events included a July 20th tournament at the Knickerbocker Country Club and an August 9 event at the Baltusrol Golf Club.

Pioneer Women Physicians

Tribute is being paid to pioneer women physicians of New Jersey in an exhibit by the University Libraries of UMDNJ. The show is in the exhibition gallery of the George F. Smith Library of the Health Sciences on the Newark campus.

Twenty pioneer women physicians are featured in the display which officially opened on June 2, with a reception honoring Dr. Palma Formica, the first woman president of the Medical Society of New Jersey.

In addition to Dr. Formica, five other living "pioneers" attended the opening:

- Dr. Eva T. Brodtkin, first woman dermatologist in New Jersey and the first woman president of the Dermatological Society of New Jersey.

- Dr. Christine Haycock, the first woman to transfer from the U.S. Army Nurse Corps to the U.S. Army Medical Corps. Dr. Haycock was the first woman to head a major U.S. Army Reserve Unit in the state.

- Dr. E. Mae McConnell, the first black appointed to the staff of Newark City Hospital and former president of the New Jersey State Medical Association.

- Dr. Laura Morrow, of Clifton,

president of the New Jersey Psychiatric Association and former president of the American Medical Women's Association.

- Dr. Mathilda Vaschak, the first woman medical director of a corporation in New Jersey, and the first woman chairman of the Occupational Medical Society of New Jersey.

There are 13 additional women physicians, including:

- Dr. Sarah F. Mackintosh (1836-1903), the first woman member of the Passaic County Medical Society, who in 1874 became the first woman member of the Medical Society of New Jersey.

- Dr. Dorothy K. Klughaupt (1909-1976), the first woman president of the Passaic County Medical Society; she was the first woman president of the Passaic General Hospital Staff.

- Dr. Mary J. Dunlap, the first woman president of the Association of Medical Officers of American Institutions for Feeble-Minded Per-

sons, now the American Association for Mental Retardation. In 1904, Dr. Dunlap was elected the first woman president of the Cumberland County District Medical Society. She was the first woman to be president of a county medical society in New Jersey.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Kenneth Lum, M.D., 7240 Twin Eagle Lane, Fort Myers, FL 33912. Downstate 1985. Board eligible. Available.

CARDIOLOGY—Donald G. Rubenstein, M.D., 1037 3rd St., #303, Santa

Monica, CA 90403. Louisiana 1980. Board eligible. Group or partnership. Available.

DERMATOLOGY—Cheryl S. Citron, M.D., 885 Sussex Rd., San Marino, CA 91108. Miami 1984. Board eligible. Group, partnership, solo. Available.

ENDOCRINOLOGY—Robert P. Castellucci, M.D., 3509 Kensington Ave., #3, Richmond, VA 23221. St. George's 1982. Board eligible. Partnership or group. Available September 1988.

FAMILY MEDICINE—John Travers, M.D., 14225 Kendra Way, Poway, CA 92064. UMDNJ 1982. Group or HMO. Available.

INTERNAL MEDICINE—Marc Hanfling, D.O., 26 Glen Lane, Cherry Hill, NJ 08002. New York College 1981. Also, cardiology. Board certified. Board eligible (CARD). Group, partnership, solo. Available.

Lalitha B. Iyer, M.D., 84 Hempstead Dr., Somerset, NJ 08873. Madras (India) 1980. Board eligible. Group, partnership, emergency room. Available.

Joseph T. Wayne, M.D., 106 Elmwood Dr., Prudenville, MI 48651. SUNY-Buffalo 1982. Board eligible. Board certified (PED). Also, pediatrics. Group, partnership, academic. Available October 1988.

PEDIATRICS—Linda York-Chance, M.D., 435 East 70th St., New York, NY 10021. Connecticut 1985. Board eligible. Clinic or emergency room. Available.

Iraj Modarai, M.D., 40 Cherry Hill, Springfield, VT 05156. Tabriz (Iran) 1956; Polyclinic 1963. Board certified. Clinic, emergency, salary. Available.

Joseph T. Wayne, M.D., 106 Elmwood Dr., Prudenville, MI 48651. SUNY-Buffalo 1982. Also, internal medicine. Board certified. Board eligible (IM). Group, partnership, academic. Available.

PHYSICAL MEDICINE AND REHABILITATION—Robert B. Thorne, M.D., 1219 East Northern Pkwy., Baltimore, MD 21239. Rutgers 1980. Board certified. Available.

PSYCHIATRY—Jozsef Telkes, M.D., c/o John Black, 3901 Crosswicks-Hamilton Square Rd., Robbinsville, NJ 08691. Pecs (Hungary) 1978. Board certified. Group or research. Available September 1988.

SURGERY—Andrea Resciniti, M.D., 4 Duncannon Ave., Apt. 9, Worcester, MA 01604. Hahnemann 1983. Board eligible. HMO, multispecialty, group, single specialty group. Available.

UROLOGY—Joseph G. Colonna, M.D., 503 Captain Dement Dr., Waldorf, MD 20601. Guadalajara 1977. Board certified. Group, partnership, solo. Available.



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ANESTHESIOLOGY

September

- 27 **NJSSA—General Membership Meeting**
6-10 P.M.—Ramada Inn, Clark (NJSSA)

CARDIOLOGY

September

- 21 **Practice Management and Various Modalities of Treatment**
1-2 P.M.—West Hudson Hospital, Kearny (West Hudson Hospital)
- 28 **Advanced Cardiac Life Support**
6 P.M.—Freehold Area Hospital, Freehold (Freehold Area Hospital)

October

- 5 **Advanced Cardiac Life Support**
6 P.M.—Freehold Area Hospital, Freehold (Freehold Area Hospital)

DERMATOLOGY

September

- 6 **Dermatological Society of New Jersey**
7-10 P.M.—Schering-Plough Corporation, Kenilworth

(Dermatological Society of New Jersey)

21 Dermatology Conferences

6-9 P.M.—Rutgers Community Health Plan, 57 U.S. Highway 1, New Brunswick (UMDNJ)

October

- 11 **Dermatological Society of New Jersey**
7-10 P.M.—Schering-Plough Corporation, Kenilworth (Dermatological Society of New Jersey)
- 19 **Dermatology Conferences**
6-9 P.M.—Rutgers Community Health Plan, 57 U.S. Highway 1, New Brunswick (UMDNJ)
- 19 **Insights into Clinical and Investigative Pediatric Dermatology**
12 noon-6:30 P.M.—Robert Wood Johnson Medical School, Medical Education Building, New Brunswick (UMDNJ)

MEDICINE

September

- 2 **Clues to the Diagnosis of Environmental Lung Disease**
9-10 A.M.—St. Francis Medical Center, Trenton (AMNJ)
- 6 **Superior Vena Cava Syndrome**
7-8 P.M.—West Hudson Hospital, Kearny (West Hudson Hospital)
- 6 **Cranio-Facial Abnormalities**
8:30-9:30 A.M.—Newark Beth Israel Medical Center, Newark (Newark Beth Israel Medical Center)
- 12 **AIDS**
7-8 P.M.—Wallkill Valley General Hospital, Sussex (AMNJ)
- 14 **New Physician Program**
24 8 A.M.-4:30 P.M.—Medical Society of New Jersey Headquarters, Lawrenceville (MIENJ)

- 14 **Clues to the Diagnosis of Environmental Lung Disease**
12 noon-1 P.M.—St. James Hospital, Newark (AMNJ)

- 16 **Clues to the Diagnosis of Environmental Lung Disease**
8:30-9:30 A.M.—United Hospitals Medical Center, Newark (AMNJ)

- 19 **Role of Intraoperative Cholangiogram**
8-9 A.M.—West Hudson Hospital, Kearny (West Hudson Hospital)

- 22 **Thyroid Diseases**
7:30-8:30 A.M.—Atlantic City Medical Center, Atlantic City (AMNJ)

- 22 **Management of Diabetic Foot Infections**
11 A.M.—St. Joseph's Hospital and

Medical Center, Paterson (St. Joseph's Hospital and Medical Center)

- 23 **Clues to the Diagnosis of Environmental Lung Disease**
12 noon-1 P.M.—Freehold Area Hospital, Freehold (AMNJ)

- 24 **Alternative Career Choices**
9 A.M.—New Jersey Medical School, Newark (UMDNJ)

- 24-25 **Seventh Annual Advances in Pain Management**
8 A.M.—Vista Hotel, New York City (UMDNJ)

- 26 **Clues to the Diagnosis of Environmental Lung Disease**
11:30-12:30 P.M.—East Orange General Hospital, East Orange (AMNJ)

- 27 **Snake Bites**
8-10 P.M.—The Englewood Club, Englewood (Englewood Surgical Society)

- 30 **Trauma Rehabilitation**
11:30-12:30 P.M.—St. Lawrence Rehabilitation Center, Lawrence Road, Lawrenceville (St. Lawrence Rehabilitation Center)

October

- 4 **Hirsutism**
7-8 P.M.—West Hudson Hospital, Kearny (West Hudson Hospital)

- 5 **Intensive Review of Medicine**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth (Cornell University Medical College and the National Institutes of Health)

- 5 **Sports Medicine 1988**
9 A.M.-1:15 P.M.—Medical Society of New Jersey Headquarters, Lawrenceville (MSNJ)

- 12 **Medical Legal Issues in Physician's Office Practice**
10:30-11:30 A.M.—The General Hospital Center at Passaic (The General Hospital Center at Passaic)

- 13 **General Use of Opiate Analgesics and Future Directions**
11 A.M.—St. Joseph's Hospital and Medical Center, Paterson (St. Joseph's Hospital and Medical Center)

- 17 **Morbidity/Mortality**
8-9 A.M.—West Hudson Hospital, Kearny (West Hudson Hospital)

- 19 **Human Immunodeficiency Virus: Biology, Pathogenesis, and Treatment**
3:30-5:30 P.M.—Drew University Campus, Madison (Drew University and Ciba-Geigy Pharmaceuticals Division)

- 22 **Before You Borrow—A Prescription for Practice Start Up**
9 A.M.—New Jersey Medical School, Newark (UMDNJ)

- 27 What Works and Doesn't Work in Type II Diabetes**
11 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(*St. Joseph's Hospital and Medical Center*)

NEPHROLOGY

October

- 18 Potassium**
6:30-9 P.M.—Center for Community Health, Overlook Hospital, Summit
(*Nephrology Society of New Jersey*)

OBSTETRICS/GYNECOLOGY

September

- 28 Perinatal Care and the Working Woman**
8 A.M.-3 P.M.—Holiday Inn, Jamesburg
(*Perinatal Association of New Jersey*)

October

- 12 From Fetus to Newborn**
9:30-4:30 P.M.—Woodbridge Hilton Hotel, Woodbridge
(*Newark Beth Israel Medical Center*)

ONCOLOGY

September

- 8- Second Conference on Radioimmunodetection and Radioimmunotherapy of Cancer**
8 A.M.-6 P.M.—Scanticon, Princeton
(*UMDNJ*)
- 15 Head and Neck Section**
6-9 P.M.—The Manor, West Orange
(*AMNJ*)
- 15 Tumor Board Conference**
12 noon-1 P.M.—Newcomb Medical Center, Vineland
(*Newcomb Medical Center*)

October

- 25 Tumor Conference**
12 noon-1 P.M.—Community Memorial Hospital, Toms River
(*Community Memorial Hospital*)
- 27 Tumor Board Conference**
12 noon-1 P.M.—Newcomb Medical Center, Vineland
(*Newcomb Medical Center*)

PEDIATRICS

September

- 28 The Dysmorphic Child**
9 A.M.-3 P.M.—Children's Specialized Hospital, Mountainside
(*Children's Specialized Hospital*)

PSYCHIATRY

September

- 1 Research in Treating Alcoholism**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)
- 8 Alcoholic Family**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)
- 15 Electroconvulsive Therapy**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)
- 28 Ethics and Clinical Psychiatry**
9 A.M.-5 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)
- 29 AIDS: Psychiatric Manifestations**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)

October

- 6 Fits, Faints, and Facsimiles: Psychiatric Aspects of Epilepsy**

12 noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)

13 Polymyalgia Temporal Arthritis: The Great Imposters

12 noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)

26 Middle Age and Health

9 A.M.-5 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)

RADIOLOGY

October

- 11 Pediatric Radiology**
6-9:30 P.M.—The Meeting Place, Hackensack
(*Teaneck Radiology Center*)
- 20 Interventional Radiology, Help or Hindrance to the Vascular Surgeon**
5-6 P.M.—Shore Memorial Hospital, Somers Point
(*Shore Memorial Hospital*)

SURGERY AND SURGICAL SPECIALTIES

September

- 9 High-Risk Surgery**
7:30-8:30 A.M.—Freehold Area Hospital, Freehold
(*AMNJ*)
- 27 Snake Bites**
8-10 P.M.—Englewood Club, Englewood
(*Englewood Surgical Society*)

October

- 25 Treatment of Impotency**
8-10 P.M.—Englewood Club, Englewood
(*Englewood Surgical Society*)

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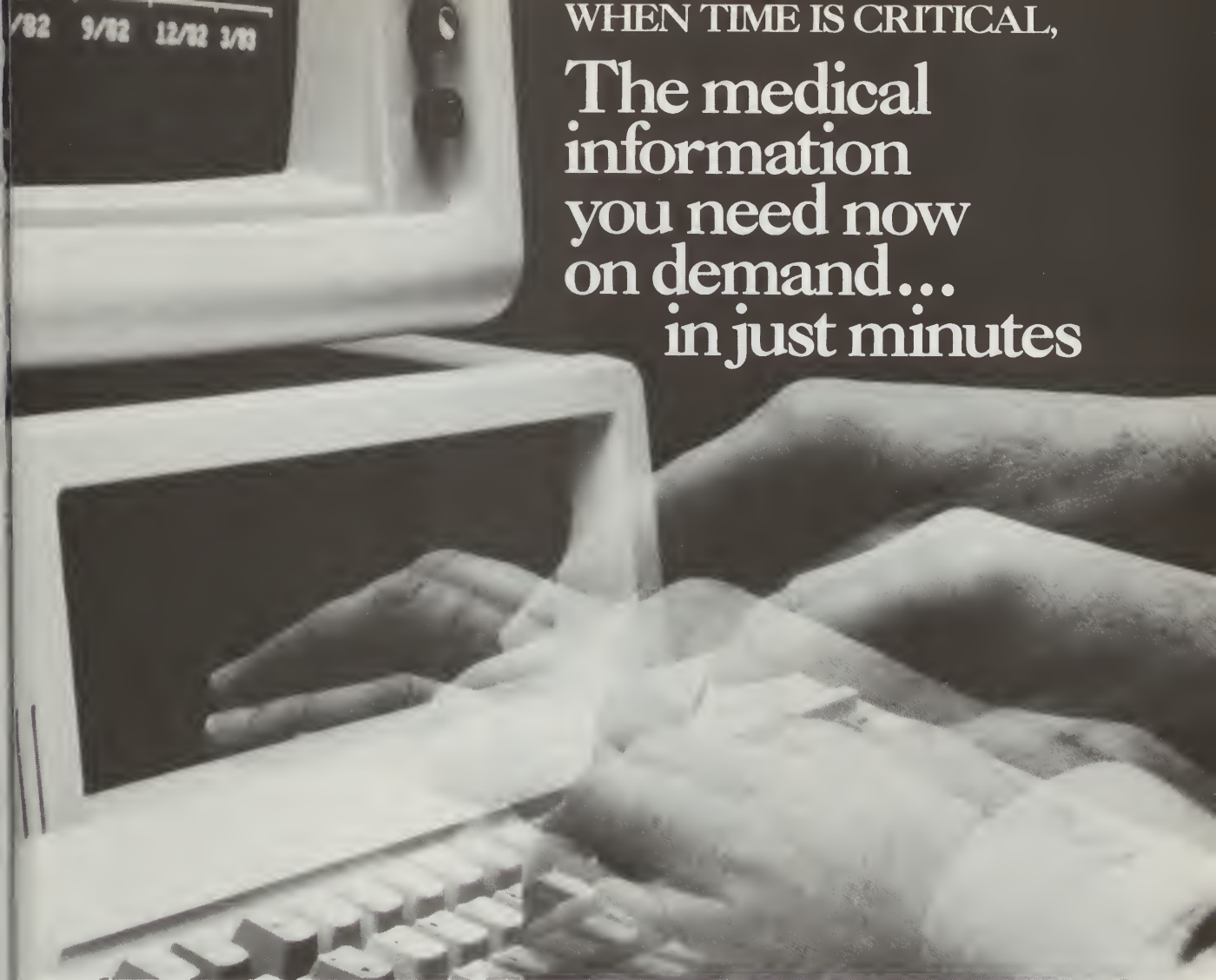
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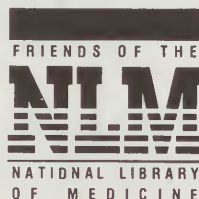


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LETTERS TO THE EDITOR

A Feasible Solution

Dear Doctor Slobodien:

I am writing this letter in response to an article by Arthur Bernstein, M.D., which appeared in your March 1988 issue. Dr. Bernstein concludes his article, "A Feasible Solution," with the statement, "The answer with which we are left is a well-planned relative value scale agreed upon by all concerned."

On the surface this appears to be an ideal solution to the problem of physician reimbursement. It is, however, a naive comment since there is no way in which "all concerned" will agree with any relative value scale. The reason for this is that there is obvious competition on the part of nonsurgical practitioners to increase the rate at which they are paid relative to that of surgical practitioners. This ideally could be done either by raising the fees of nonsurgeons or lowering the fees of surgeons. What actually will happen is the differential in reimbursement for surgical versus nonsurgical services may be reduced; it will be accomplished by lowering reimbursement for all services. Any such proposal offered by physicians to the government will thus be a disastrous one because the government is interested mainly in cost containment and only secondarily, if at all, in quality of care. What will happen is the government will adopt all cost-

saving measures that are offered. An example is the offer of ophthalmologists to accept a decrease in reimbursement for preoperative cataract ultrasound examinations as opposed to taking a cut in the allowance for the surgery. The government not only cut the allowance for surgery, but seized upon the novel idea offered by the ophthalmologists and combined the surgical fee cut with a cut in reimbursement for ultrasound examination.

Based on past performance, we can expect that any attempt to decrease the gap between reimbursement for surgical and nonsurgical procedures will result in less reimbursement for all procedures and no one in the medical profession will gain.

Another unrelated point I wish to raise is the approach that the Medical Society should take with respect to mandatory Medicare assignment. We can be certain that in some shape or way this will be with us in years to come. Both of the leading candidates for the Democratic presidential nomination are strongly in favor of mandatory assignment. Mr. Dukakis signed into law the first such proposal and Governor Cuomo has come out strongly in favor of a similar plan. I feel the only way we can have something which will be at least partially acceptable would be for the Medical Society of New Jersey to propose a mandatory assignment program based on a means test. I propose that any person on Medicare who qualifies for the New Jersey Pharmaceutical Assistance to the Aged and Disabled Program (PAAD) not be charged for medical services and that the physicians accept Medicare assignment. This would produce little if any hardship on physicians since I am certain that practically all of us accept assignment on a voluntary basis for patients with limited means.

There is no reason for physicians to have to accept assignment on persons who can afford to pay. If the Medicare program is short on funds and the government wishes to limit the amount they wish to pay for a given procedure, it will not save the government additional money if doctors' fees are limited. I have, to date, not heard of any plan by the government to insist that the reduction in fees forced upon physicians for Medicare patients are being pro-

posed in any similar manner for other professions or businesses. I do not think the government is yet ready to tell Lee Iacocca that he must give 30 percent discounts to senior citizens who purchase his automobiles. The telephone company has not been ordered to provide mandatory discounts to senior citizens. I am certain that Prudential Insurance Company is not giving 30 percent discounts to senior citizens.

(signed) Marvin F. Kraushar, M.D.

Dear Doctor Kraushar:

You insist that the idea of a "relative value scale" agreed upon by all concerned, is a "naive comment." At the present time, there has been agreement by the AMA, as well as the specialty societies, with the work presented to date.

I am not naive enough to believe that every physician will be happy with the scale presented for his specialty, but when a majority do agree, then that is the democratic way to settle this matter.

The California relative value scale was an effective fee scale for many years, though I am certain it had some inequities as does any fee scale, including so-called "fee for service" (unrestricted) which I must assume you favor. As I tried to point out, the patients no longer will stand for a "get-as-much-as-possible" fee schedule for medical care. So the wise man bows to the will of the people and makes the necessary accommodations, as all the specialty societies and the AMA have done.

I am as opposed to regimentation as you obviously are, but there comes a time where the reputation of the physician as a caring healer preempts the need for unrestricted fees. The public feels, correctly or incorrectly, that we are gouging them by our fees. This concept must be altered or we will never regain our status as the patient's advocate. At the moment, the relative value scale as it is being set up seems to be a valid methodology.

As for "mandatory assignment," I agree with you fully!

(signed) Arthur Bernstein, M.D.

Editor's Note: MSNJ sponsors a senior medical courtesy program, as discussed in the May 1988 issue of *NEW JERSEY MEDICINE* (p. 352).

Allergic Diseases from Infancy to Adulthood; Annual Review of Medicine; Evaluation of Isokinetic Equipment; Human Inflammatory Diseases

Allergic Diseases from Infancy to Adulthood. Second Edition.

C. Warren Bierman, M.D., and David S. Pearlman, M.D. Philadelphia, PA, W.B. Saunders Company, 1988. Pp. 848. (\$95)

Allergic Diseases From Infancy to Adulthood is the second edition of a textbook which previously had concerned itself with allergic problems in infants and children. It now has been extended to include adult allergic disease. The authors have enlisted the aid of some of the outstanding researchers and writers in the field of allergy and clinical immunology and have concentrated on clinical management.

The first two sections are devoted to basic physiology and pathology and are excellent reviews. Particularly outstanding is the section on host-defense systems and cytokines. Any physician or upper-level medical student would find this, by itself, a well-written monograph on current concepts in clinical immunopathology.

The outstanding chapters on clinical allergy are: adverse reactions to foods (John Anderson); identification of pollen and fungus allergens (William Solomon); atopic

dematitis, and a clinical review of upper respiratory tract diseases.

The only weak link in the text is the section on urticaria. The chapters on pharmacologic management are good, but there is too much emphasis on theophylline and not enough detail on corticosteroid therapy.

In summary, I found this to be a scholarly, well-written text; and although the author recommends this book for the practicing physician, it would be worthwhile for the allergy specialist as well.

Donald G. McKaba, M.D.

Annual Review of Medicine: Selected Topics in the Clinical Sciences

William P. Creger (ed). Palo Alto, CA, Annual Review, Inc., 1988. (\$34)

The Annual Reviews, Inc., is a nonprofit scientific publisher established to promote the advancement of sciences. Since 1932, the company has pursued (as its principal function) the publication of high-quality, reasonably priced annual review volumes. These books are organized by editors and editorial committees who invite qualified authors to contribute critical articles of significant developments within each major scientific discipline.

This 39th volume of the *Annual Review of Medicine* contains 42 articles on as many various subjects covering medical illnesses, diagnoses, and therapies. Each article starts with an abstract paragraph, followed by a detailed description and discussion of the subject matter, and a final summary conclusion. Each essay is easily read, and heavily annotated with the most recent references and subject indices. Each volume published has a cumulative index of the previous five volumes by author and chapter titles.

The *Annual Review of Medicine* will find itself most frequently used or referred to in a library reference section, in hospitals, schools, or other health service facilities. It has good value as a time saver.

Harry M. Poppick, M.D.

Evaluation of Isokinetic Equipment

Terry R. Malone, Ed.D. (ed). Balti-

more, MD, Williams & Wilkins, 1988. Pp. 92.

This small book is designated as the first of a quarterly series of books on sports injury management. The aim is to acquaint the reader with various types of isokinetic rehabilitative equipment currently on the market, and it succeeds.

A detailed description, with illustrations, is given of six of the major systems in use. Advantages and disadvantages of this machinery are listed. A final chapter summarizes the data on the various equipment and makes suggestions for the newcomer, as well as points out that machinery is only one aspect of the rehabilitation process.

The book is a good reference text for personnel in all fields of physical medicine and orthopedics who might have reason to use or prescribe the use of isokinetic rehabilitative equipment.

Christine E. Haycock, M.D.

Human Inflammatory Diseases. Clinical Immunology. Volume I.

Gianni Marone, M.D., Lawrence M. Lichtenstein, M.D., Ph.D., Mario Condorelli, M.D., Anthony S. Fauci, M.D. Philadelphia, PA, B.C. Decker Inc., 1988. Pp. 327.

This volume represents the topics and discussions presented at the first Capri conference on clinical immunology held in the summer 1986. The text covers a wide spectrum of topics discussed in the four symposiums given at the conference including immunology of pulmonary disorders, cardiac immunology, adenosine metabolism and receptors, and basic immunologic and biochemical mechanisms involved in rheumatic disorders.

The text is an up-to-date, well-referenced text with many distinguished international authors including Anthony Fauci (vasculitis), Roberto Levi (cardiac anaphylaxis), Charles Cochrane (lung injury), Lawrence Lichtenstein (basophils and mast cells), John Stobo (antigen receptor complex), and Giovanni Camussi (platelet activating factor). The text is read easily and is appropriate for physicians interested in the basic science of inflammation associated with pulmonary, cardiac, autoimmune, and musculoskeletal systems.

Leonard Bielory, M.D.

ark. From 1955 to 1957, he served as a captain in the United States Army medical corps.

Dr. Walter H. Cole

Retired industrial medicine specialist Walter Horace Cole, M.D., of Elizabeth, died on April 13, 1988, at the age of 83. Born in Elizabeth and a life-long area resident, Dr. Cole received his medical degree at the University of Pennsylvania School of Medicine, Philadelphia, in 1929. He became affiliated with Elizabeth General Medical Center, St. Elizabeth Hospital, and Alexian Brothers Hospital, all in Elizabeth. Dr. Cole was a member of our Union County component and of the AMA. He received the Medical Society of New Jersey's Golden Merit Award in 1979, for 50 years of service as a physician.

Dr. Frederick C. DeTroia

Specialist in surgery and gynecology Frederick Carl DeTroia, M.D., died on February 24, 1988, at the age of 77. A Newark native, Dr. DeTroia was graduated from Jefferson Medical College, Philadelphia, Pennsylvania, in 1935. He maintained private practices in Newark and South Orange, and was affiliated with Saint Michael's Medical Center, Newark City Hospital, and Presbyterian Hospital, all in Newark; as well as Saint Barnabas Medical Center, Livingston. A fellow of the International College of Surgeons, Dr. DeTroia was a member of our Essex County component, of the Essex County Pathological Society, and of the AMA. During World War II, he was a major in the United States Air Force. In 1985, Dr. DeTroia received the Medical Society of New Jersey's Golden Merit Award, for 50 years of medical practice.

Dr. Allan A. Klein

Allan A. Klein, M.D., specialist in traumatology and general industrial surgery, died on July 22, 1987, at the age of 77. Born in Jersey City, Dr. Klein received his medical degree at New York Medical College, in 1933. He became affiliated with Christ Hospital and Jersey City Medical

Center, both in Jersey City; Paliades General Hospital, North Bergen; and the Englewood Hospital Association. Dr. Klein was a member of our Hudson County component. In 1983, he received the Golden Merit Award.

Dr. Leo Schwartz

Retired Passaic physician Leo Schwartz, M.D., died on May 4, 1988, at the age of 79. A native of New York City, Dr. Schwartz received his medical degree at the University of Arkansas Medical School, in 1935. He practiced medicine in Passaic for 40 years, and was a United States Army veteran of World War II. Dr. Schwartz was a member of our Passaic County component and of the AMA. In 1985, he received MSNJ's Golden Merit Award.

Dr. Salomon Silvera

Radiologist Salomon Silvera, M.D., died on March 3, 1988, at the age of 82. Born in Cairo, Egypt, Dr. Silvera received his medical degree from the University of Berlin, Germany, in 1929. He became affiliated with Christ Hospital, Jersey City, and UMDNJ-University Hospital, Newark. Dr. Silvera also maintained a private practice in Jersey City. A diplomate in radiology and a fellow of the American College of Radiology, Dr. Silvera was a member of our Hudson County component and of the AMA. During World War II, he was a major in the U.S. Army medical corps. He was a 1979 recipient of the Golden Merit Award.

Dr. David Wiener

Retired surgeon David Wiener, M.D., died on March 8, 1988, at the age of 76. Dr. Wiener attended Indiana University School of Medicine, receiving his medical degree in 1938. A fellow of the American College of Angiology and of the American College of Surgeons, Dr. Wiener was a member of our Essex County component and of the American Medical Association. He was affiliated with Clara Maass Medical Center, Belleville, and Newark Beth Israel Medical Center, among others. Dr. Wiener received MSNJ's Golden Merit Award in 1988.

***Drs. Austin; Carlin; Cole;
DeTroia; Klein; Schwartz;
Silvera; Wiener***

Dr. Thomas R. Austin

General practitioner Thomas Ralph Austin, M.D., died on April 30, 1988, at the age of 86. Dr. Austin attended Cornell University Medical College, New York, where he received his medical degree in 1932. He maintained a private practice in Cranford. During World War II, Dr. Austin served in the United States Army medical corps, attaining the rank of major. He was a member of our Union County component and of the AMA. In 1982, Dr. Austin received MSNJ's Golden Merit Award for his 50 years as a physician.

Dr. Daniel J. Carlin

Specialist in neurology and electroencephalography Daniel Joseph Carlin, M.D., died on April 25, 1988, at the age of 60. Born in Brooklyn, New York, Dr. Carlin received his medical degree from Galway National University of Ireland in 1954. A diplomate in neurology and a member of our Morris County component, Dr. Carlin was affiliated with Morristown Memorial Hospital, Summit; and UMDNJ-Robert Wood Johnson University Hospital, New-

AUTHOR INFORMATION

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CONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable

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The **summary** of the article should not exceed 250 words; it should contain only essential facts.

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1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

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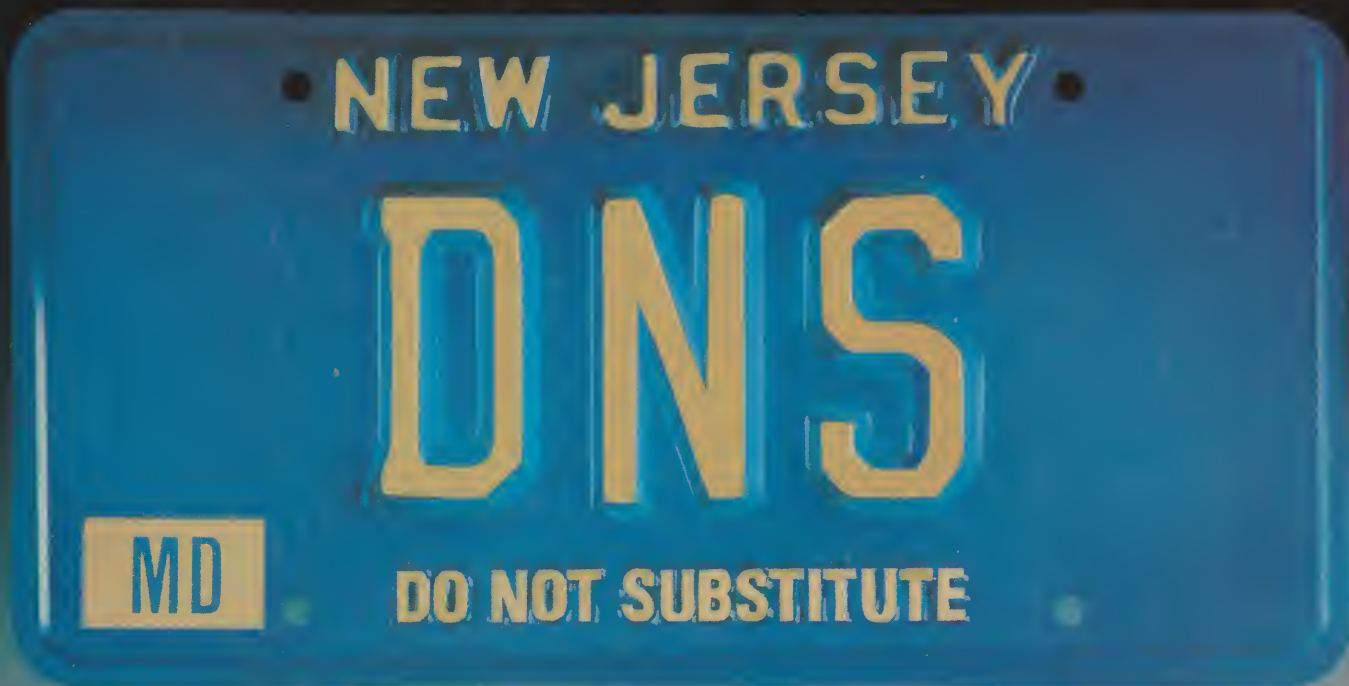
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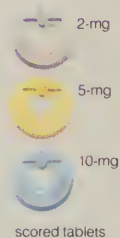
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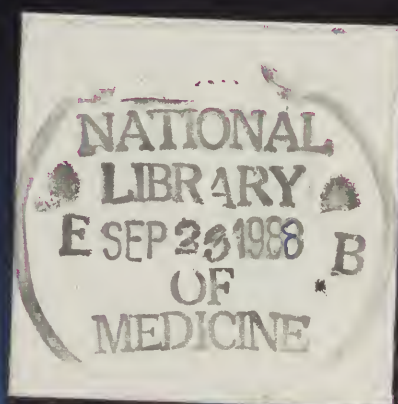
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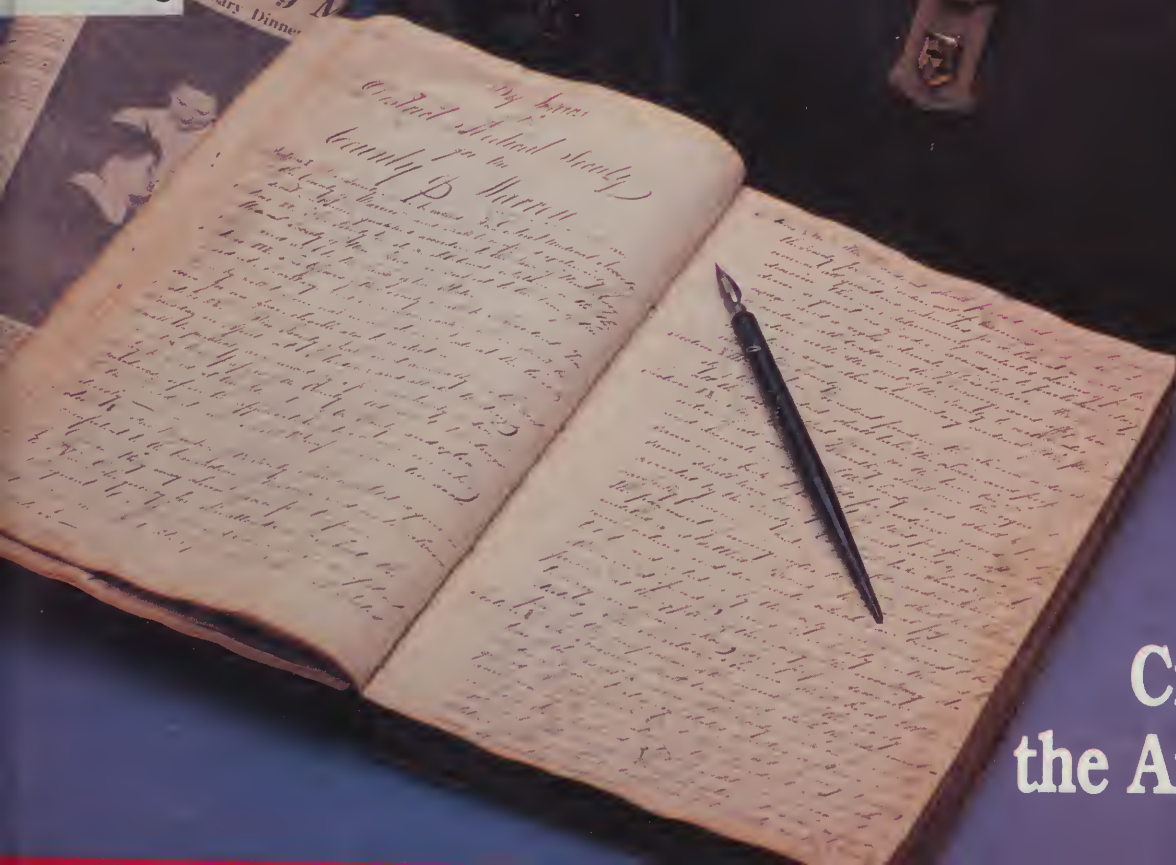
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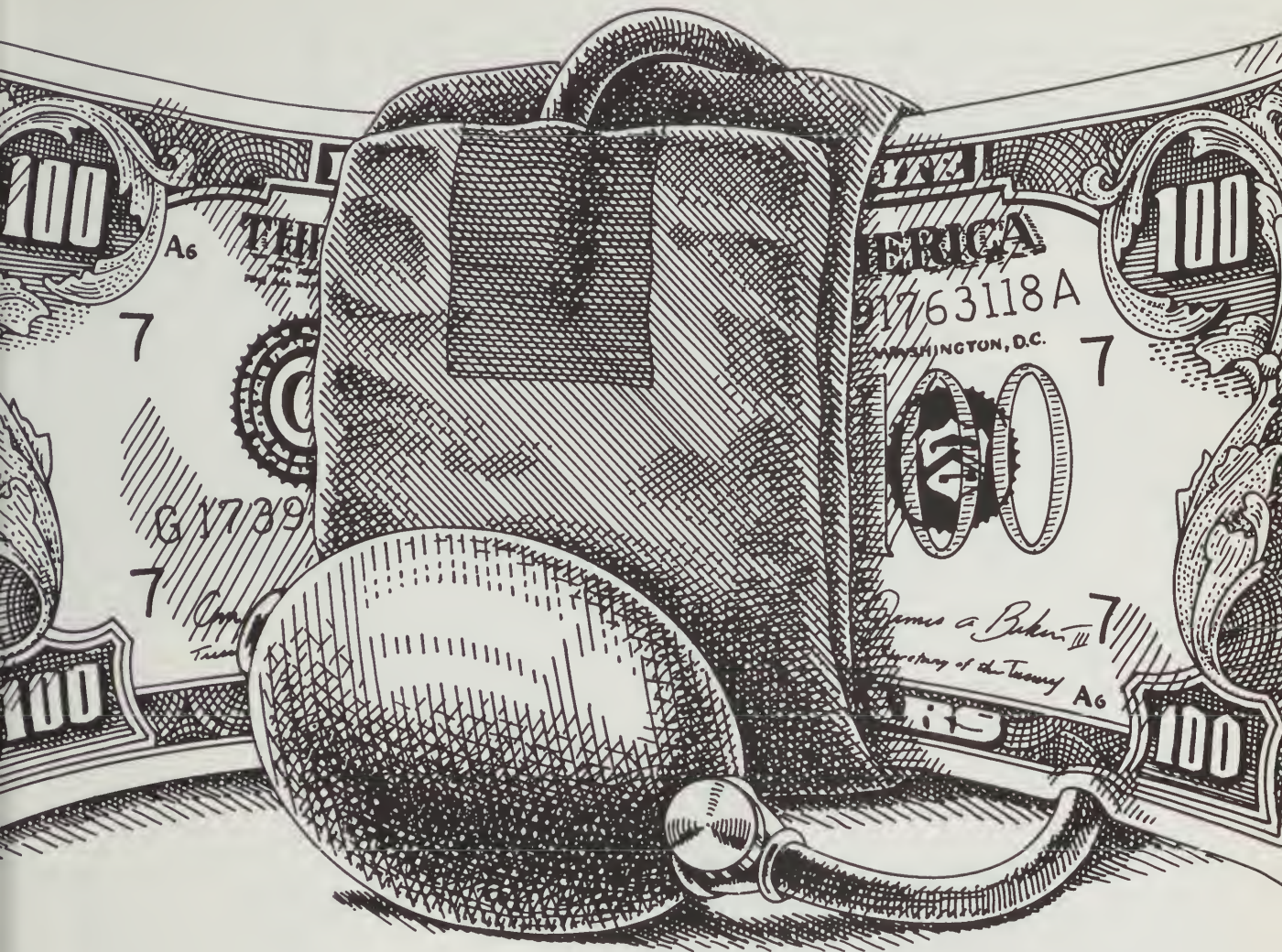
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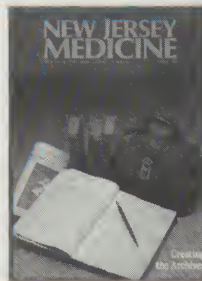
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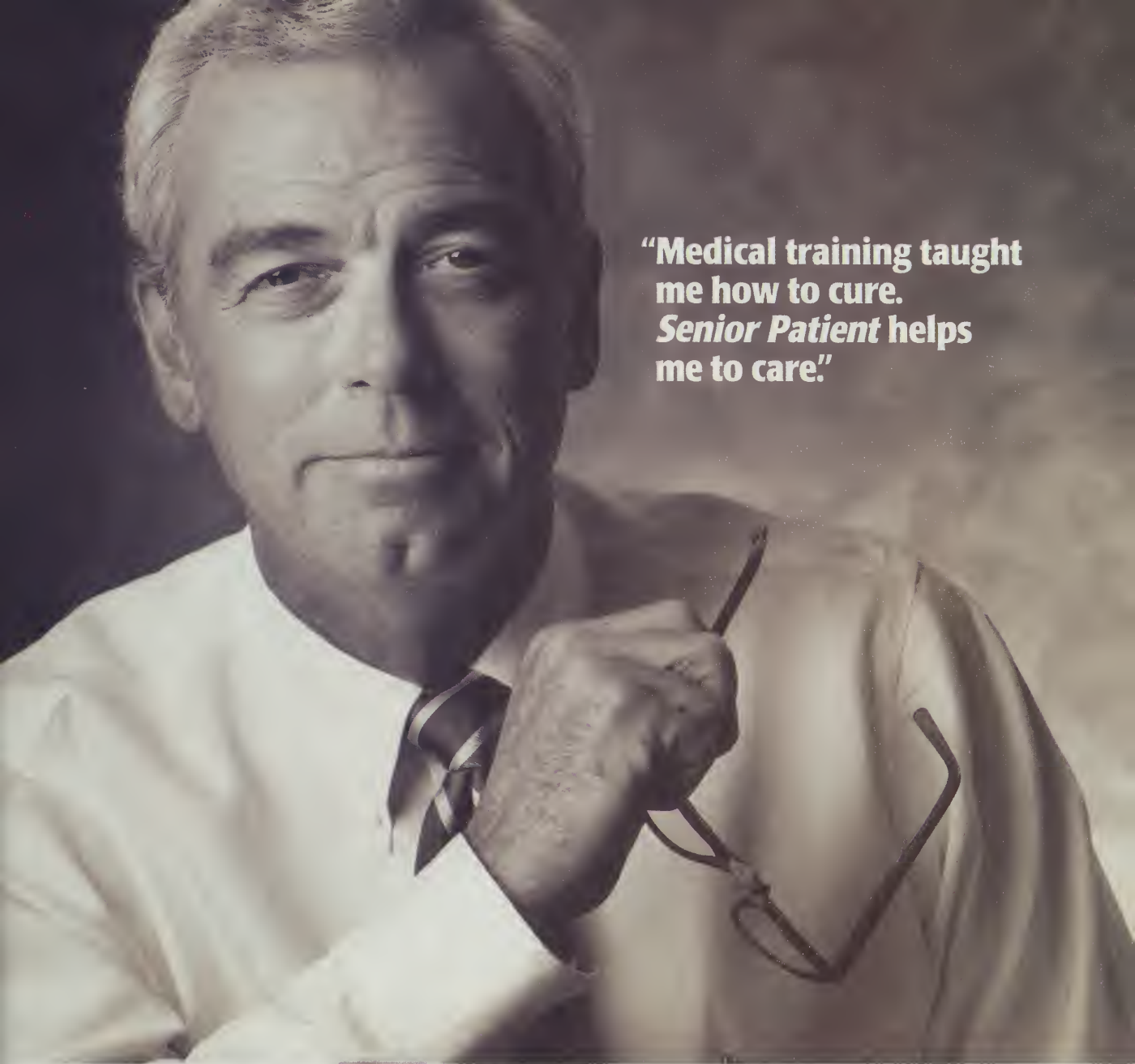
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On The Cover: Preserving and archiving the history of the Medical Society of New Jersey was completed. The story begins on page 734. Cover and photographs: Spud Grammar.





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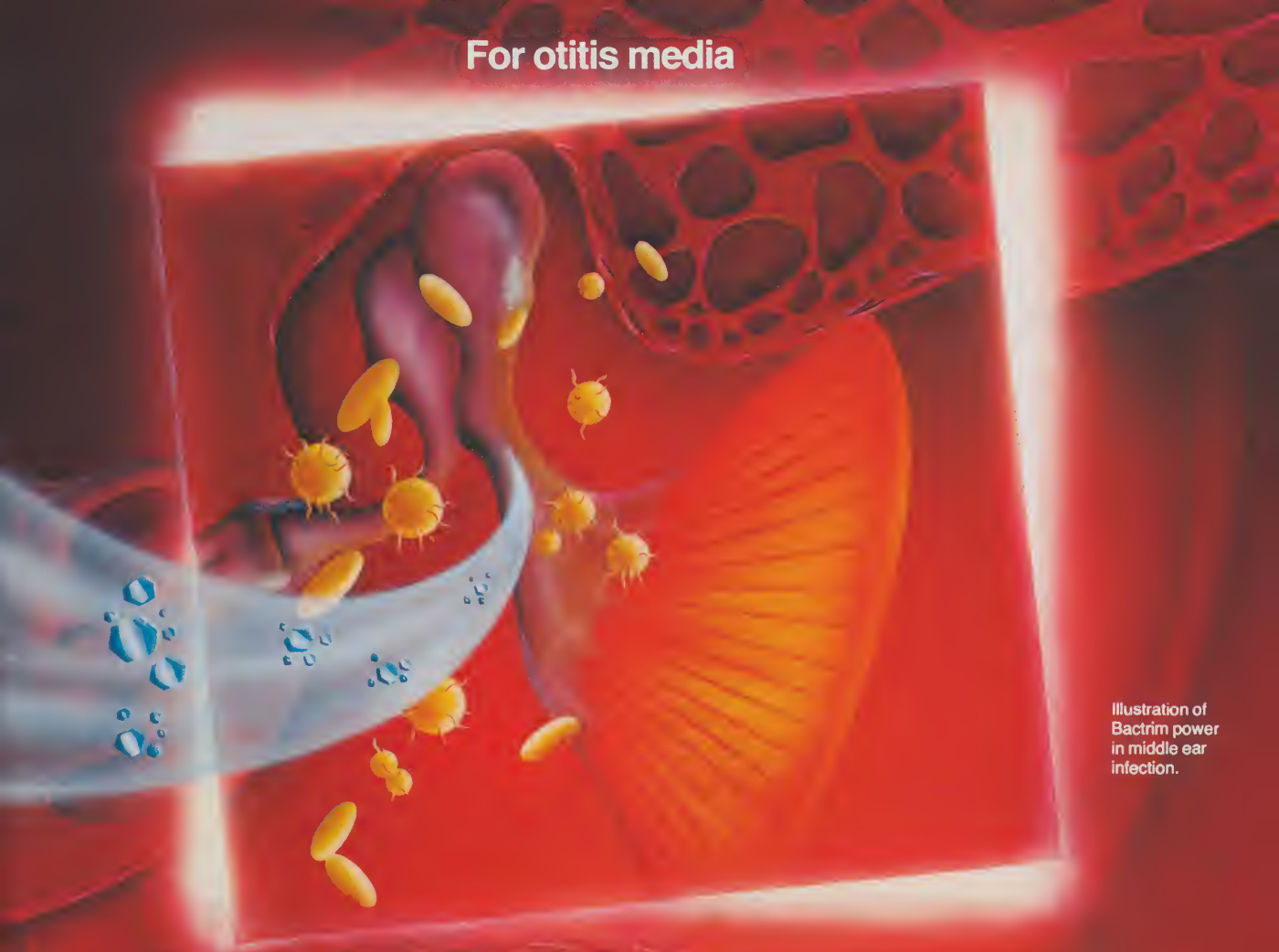


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WARNINGS: FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS.

BACTRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. Clinical signs, such as rash, sore throat, fever, arthralgia, cough, shortness of breath, pallor, purpura or jaundice, may be early indications of serious reactions. In rare instances a skin rash may be followed by more severe reactions, such as Stevens-Johnson syndrome, toxic epidermal necrolysis, hepatic necrosis or serious blood disorder. Perform complete blood counts frequently. **BACTRIM SHOULD NOT BE USED IN THE TREATMENT OF STREPTOCOCCAL PHARYNGITIS.** Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have a greater incidence of bacteriologic failure when treated with Bactrim than with penicillin.

PRECAUTIONS: General: Give with caution to patients with impaired renal or hepatic function, possible folate deficiency (e.g., elderly, chronic alcoholics, patients on anticonvulsants, with malabsorption syndrome, or in malnutrition states) and severe allergies or bronchial asthma. In glucose-6-phosphate dehydrogenase deficient individuals, hemolysis may occur, frequently dose-related.

Use in the Elderly: May be increased risk of severe adverse reactions in elderly, particularly with complicating conditions, e.g., impaired kidney and/or liver function, concomitant use of other drugs. Severe skin reactions, generalized bone marrow suppression (see WARNINGS AND ADVERSE REACTIONS) or a specific decrease in platelets (with or without purpura) are most frequently reported severe adverse reactions in elderly. In those concurrently receiving certain diuretics, primarily thiazides, increased incidence of thrombocytopenia with purpura reported. Make appropriate dosage adjustments for patients with impaired kidney function (see DOSAGE AND ADMINISTRATION).

Use in the Treatment of Pneumocystis Carinii Pneumonia in Patients with Acquired Immunodeficiency Syndrome (AIDS): AIDS patients may not tolerate or respond to Bactrim in same manner as non-AIDS patients. Incidence of side effects, particularly rash, fever, leukopenia, elevated aminotransferase (transaminase) values, with Bactrim in AIDS patients treated for *Pneumocystis carinii* pneumonia reported to be greatly increased compared with incidence normally associated with Bactrim in non-AIDS patients.

Information for Patients: Instruct patients to maintain adequate fluid intake to prevent crystalluria and stone formation.

Laboratory Tests: Perform complete blood counts frequently; if a significant reduction in the count of any formed blood element is noted, discontinue Bactrim. Perform urinalyses with careful microscopic examination and renal function tests during therapy, particularly for patients with impaired renal function.

Drug Interactions: In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombocytopenia with purpura has been reported. Bactrim may prolong the prothrombin time in patients who are receiving the anticoagulant warfarin. Keep this in mind when Bactrim is given to patients already on anticoagulant therapy and reassess coagulation time. Bactrim may inhibit the hepatic metabolism of phenytoin. Given at a common clinical dosage, it increased the phenytoin half-life by 39% and decreased the phenytoin metabolic clearance rate by 27%. When giving these drugs concurrently, be alert for possible excessive phenytoin effect. Sulfonamides can displace methotrexate from plasma protein binding sites, thus increasing free methotrexate concentrations.

Drug/Laboratory Test Interactions: Bactrim, specifically the trimethoprim component, can interfere with a serum methotrexate assay as determined by the competitive binding protein technique (CBPA) when a bacterial dihydrofolate reductase is used as the binding protein. No interference occurs if methotrexate is measured by a radioimmunoassay (RIA). The presence of trimethoprim and sulfamethoxazole may also interfere with the Jaffe alkaline picrate reaction assay for creatinine, resulting in overestimations of about 10% in the range of normal values.

Carcinogenesis, Mutagenesis, Impairment of Fertility: *Carcinogenesis:* Long-term studies in animals to evaluate carcinogenic potential not conducted with Bactrim. *Mutagenesis:* Bacterial mutagenic studies not performed with sulfamethoxazole and trimethoprim in combination. Trimethoprim demonstrated to be nonmutagenic in the Ames assay. No chromosomal damage observed in human leukocytes *in vitro* with sulfamethoxazole and trimethoprim alone or in combination; concentrations used exceeded blood levels of these compounds following therapy with Bactrim. Observations of leukocytes obtained from patients treated with Bactrim revealed no chromosomal abnormalities. *Impairment of Fertility:* No adverse effects on fertility or general reproductive performance observed in rats given oral dosages as high as 70 mg/kg/day trimethoprim plus 350 mg/kg/day sulfamethoxazole.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Trimethoprim and sulfamethoxazole may interfere with folate acid metabolism; use during pregnancy only if potential benefit justifies potential risk to fetus. Nonteratogenic Effects: See CONTRAINDICATIONS section.

Nursing Mothers: See CONTRAINDICATIONS section.

Pediatric Use: Not recommended for infants under two months (see INDICATIONS AND CONTRAINDICATIONS sections).

ADVERSE REACTIONS: Most common are gastrointestinal disturbances (nausea, vomiting, anorexia) and allergic skin reactions (such as rash and urticaria). **FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS (SEE WARNINGS SECTION).** *Hematologic:* Anemia, leukopenia, thrombocytopenia, leukopenia, neutropenia, hemolytic anemia, megaloblastic anemia, hypoprothrombemia, methemoglobinemia, eosinophilia. *Allergic Reactions:* Stevens-Johnson syndrome, toxic epidermal necrolysis, anaphylaxis, allergic myocarditis, erythema multiforme, exfoliative dermatitis, angioedema, drug fever, chills, Henoch-Schoenlein purpura, serum sickness-like syndrome, generalized allergic reactions, generalized skin eruptions, photosensitivity, conjunctival and scleral injection, pruritus, urticaria and rash. *Periarteritis nodosa* and systemic lupus erythematosus have been reported. *Gastrointestinal:* Hepatitis (including cholestatic jaundice and hepatic necrosis), elevation of serum transaminase and bilirubin, pseudomembranous enterocolitis, pancreatitis, stomatitis, glossitis, nausea, abdominal pain, diarrhea, anorexia. *Genitourinary:* Renal failure, interstitial nephritis, BUN and serum creatinine elevation, toxic nephrosis with oliguria and anuria, crystalluria. *Neurologic:* Aseptic meningitis, convulsions, peripheral neuritis, ataxia, vertigo, tinnitus, headache. *Psychiatric:* Hallucinations, depression, apathy, nervousness. *Endocrine:* Sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents; cross-sensitivity may exist. Diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. *Respiratory:* Pulmonary infiltrates. *Musculoskeletal:* Arthralgia, myalgia. *Miscellaneous:* Weakness, fatigue, insomnia.

DOSAGE AND ADMINISTRATION: Not recommended for use in infants less than two months of age. **URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:** *Usual adult dosage* for urinary tract infections is one DS tablet, two tablets or four teaspoonsful (20 ml) b.i.d. for 10 to 14 days. Use identical daily dosage for 5 days for shigellosis. *Recommended dosage for children* with urinary tract infections or acute otitis media is 8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses every 12 hours for 10 days. Use identical daily dosage for 5 days for shigellosis. *Renal Impaired:* Creatinine clearance above 30 ml/min, give usual dosage; 15-30 ml/min, give one-half the usual regimen; below 15 ml/min, use not recommended.

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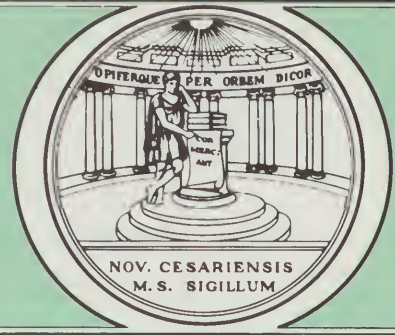
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MEMBERSHIP NEWSLETTER



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THE MEDICAL SOCIETY OF NEW JERSEY

Volume 58

PROPOSED MALPRACTICE SURCHARGE

The Medical Society of New Jersey has called on Governor Thomas H. Kean to intervene to halt an effort by the State Department of Insurance to impose more than \$60 million in the liabilities of a defunct, cut-rate medical malpractice insurance company on thousands of practicing physicians who had no involvement in the losses.

In a letter to the governor, Dr. Palma E. Formica, MSNJ president, announced the Society's availability "to meet with you and to help forge a responsible and meaningful solution" to the problem created by the deficit of the New Jersey Medical Malpractice Re-insurance Association (MMRA) which the State Insurance Department formed in 1976 and closed down in 1982. Dr. Formica wrote in response to an announcement by Insurance Commissioner Kenneth D. Merin that he was proposing a regulation that for seven years would impose a 5 percent annual surcharge on the malpractice premiums of 13,400 New Jersey physicians and podiatrists in order to eliminate the MMRA shortfall.

Dr. Formica wrote: "This Society repeatedly has advised Mr. Merin that he was not pursuing a legally acceptable, professionally competent, equitable, or feasible course for funding that deficit."

She noted that the Insurance Department permitted MMRA to write coverage at rates substantially below those of the Medical Inter-Insurance Exchange of New

Jersey (MIENJ), a pre-existing doctor-owned company with which it was competing. Physicians who joined MIENJ not only were required to pay rates higher than the state-sponsored carrier, but also contributed to the initial capital of MIENJ. Nevertheless, the majority of New Jersey's physicians joined the privately operated company which, through the payment of adequate premiums by its members, has continued to grow and provide coverage to most of the state's practicing physicians.

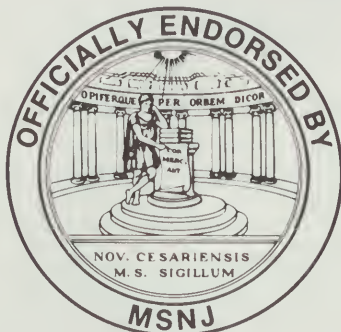
Under Commissioner Merin's proposal, physicians who are insured by MIENJ and other carriers and who, as a result, paid higher premiums, would pay the same surcharge as those doctors who took advantage of the state-sponsored "bargain." Those of MMRA's 3,300 insureds who are no longer practicing in New Jersey would pay no surcharge at all, even though they may have been responsible for losses.

Furthermore, the Medical Society objects to the fact that younger physicians who were not in practice at the time, or doctors who have moved to the state since 1982 also will be forced to subsidize the losses of those who benefited from the six years of "cut-rate" state coverage.

Another inequity in Commissioner Merin's proposal is the fact that the surcharge would not be applied to physicians who are employed by the University of Medicine and Dentistry of New Jersey or in other areas of government or to their employing agencies.

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Society Boosts Medical Waste Law

Just last month, Governors Kean and Cuomo announced their states' adoption of emergency regulations requiring special handling for medical waste. Initially, physicians will be required to submit a one-time summary of the medical waste they generate from November 15 through December 15. The report will be due in mid-January. By then, the new law should be in effect.

Responding to the deteriorating situation, the Society's Council on Legislation voted to support the inclusion of physicians and other practitioners in the medical waste disposal system which will be created by S-2343/A-2853. Having endorsed the bill, the Society also gained some important amendments along the way.

The legislation began last spring with identical measures introduced in each house. It applied to private practitioners as well as facilities such as hospitals and laboratories, requiring them to separately package and identify their waste as either "general" or "special." The Assembly bill moved first, but was amended to exempt practitioners and to not apply to "general" waste such as for rubber gloves, tongue depressors, bandages, and other benign items.

A-2853 passed the Assembly, but practitioners were brought back into the measure by a Senate committee amendment. The rewritten bill then was merged with its Senate companion.

The current measure deals strictly with "special" waste: microbiological culture media; needles, syringes, and sharps; pathology specimens; blood products and body fluids of at least 20 cc in volume; and any disposable substance which has been exposed thereto, as determined by Health Department regulation.

Under the bill, practitioners and facilities will register with the Department of Environmental Protection, separately package "special" waste, and assure that it is handled by approved haulers.

The Society successfully urged adoption of three amendments beneficial to physicians:

- S-2343/A-2853 will set a uniform statewide procedure for disposing special medical waste. The law will supersede the current hodgepodge of local and county ordinances in effect throughout New Jersey, and will establish a reference list of state-approved haulers. No such document exists today.
- The annual registration fee charged by the DEP will reflect the volume of special waste produced by the generator. Thus, physicians will pay less than the maximum \$100 for a hospital.

- The "strict liability" section of the bill, which originally could have required an innocent practitioner or facility to pay for the cleanup of illegal discharges, has been modified. The bill now requires the DEP to attempt to determine whether the illegal discharge was committed by the generator, hauler, or disposer, and attempt to recover costs from the party at fault before assessing other parties.

With the Society's amendments, the bill will help the physician come to grips with a vexing problem—and it will help boost public confidence in medicine's commitment to a clean environment.

Aided by the Society's endorsement, a medical waste disposal bill has won unanimous approval in the Senate and is ready for final action in the Assembly.

The bill, S-2343/A-2853, was inspired by tremendous public concern about beach pollution. This summer, like last, was marred by reports of syringes and blood vials washing up on the New Jersey shore. Concern became panic when the Health Department found that the washed-up blood samples tested positive for AIDS and hepatitis.

Making the situation worse were media reports of medical waste found on the streets and in trash cans outside of laboratories and physicians' offices. A lab in Perth Amboy was charged by the Attorney General with dumping infectious waste and had its license suspended. A group of urologists, also in Perth Amboy, was issued a summons for allegedly disposing of syringes and blood vials in the ordinary trash. A Union County pathologist found that his hauler refused to pick up ordinary trash at his office.

*Mr. Martin is MSNJ's legislative consultant.

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Court Decisions

Doctors Sued by Patients Tested for HIV Without Permission; Prisoner with AIDS Convicted of Assault with Dangerous Weapon; Quirks in Law so Lawyer and Hospital Net Full Award; Liability from Expanding Home Care Programs Poses New Worries; Hospital Liable for Staff Physician's Off-Premise Conduct; Data on Physician-Owned Companies Reveals Tremendous Growth

DOCTORS SUED BY PATIENTS TESTED FOR HIV WITHOUT PERMISSION

Three men who charged that physicians tested their blood for HIV antibodies without their permission are suing the physicians for negligence, invasion of privacy, and emotional distress in three separate Pennsylvania lawsuits.

"A very high percentage of people are being tested without the patients' knowledge and the results frequently are not given to the patients," said the Philadelphia attorney. The men, who had consulted the physicians for other reasons, were informed they had tested positive but given no counseling, he added. One plaintiff has tested negative for HIV infection in two subsequent tests, while the other two have declined to be tested again.

Two of the three "John Doe" suits filed in Philadelphia Court of Common Pleas on March 30, seek damages of \$100,000 each. The third complaint, filed March 31, in Harrisburg, seeks damages in excess of \$10,000.

One plaintiff, who also is charging breach of confidentiality, alleged that he had been hounded out of a small Pennsylvania community after rumors spread that he was dying of AIDS. The Philadelphia attorney said it was not known who might have leaked the results of the test to outsiders but speculated it may have been a technician in a laboratory where the plaintiff had been sent for a blood test. (*AIDS Policy and Law*, April 20, 1988)

PRISONER WITH AIDS CONVICTED OF ASSAULT WITH DANGEROUS WEAPON

Evidence supported the conviction of a prisoner with AIDS of assault with a dangerous weapon after he bit two correction officers, a federal trial court in Minneapolis ruled.

The prisoner bit one officer on the leg twice, leaving a four-inch saliva stain. He bit a second officer on the leg, breaking the skin and leaving a mark that was visible five months later. He stated that he intended to kill the officers.

A jury convicted the prisoner on two counts of assault with a deadly or dangerous weapon. The prisoner moved for judgment of acquittal or a new trial. He contended that the evidence was insufficient to sustain the conviction. He argued that for his mouth and teeth to be a deadly and dangerous weapon there must be sufficient evidence to show that the AIDS virus can be transmitted by a human bite.

The court said that the evidence showed that AIDS could be transmitted through bodily fluids such as blood and semen. The prisoner had been informed that he had both the AIDS virus and hepatitis antibody.

A physician testified at trial that any human bite could cause a serious infection because of the variety of infectious micro-organisms present in the mouth. He said that blood is sometimes present in the mouth, particularly if a person has ill-fitting teeth or gum problems. He stated that the prisoner had some false teeth or a bridge.

The prisoner contended that the court erred in allowing testimony as to the precautions that the officers were instructed to take to avoid infecting their families. The court said that this testimony did not require a new trial. Rather, the court said that it was probative of the dangerousness of the bites inflicted and that its probative value outweighed any prejudicial effect. (Reprinted from *THE CITATION* with permission, American Medical Association, 535 N. Dearborn Street, Chicago, IL 60610, February 15, 1988, Volume 56, No. 9)

QUIRKS IN LAW SO LAWYER AND HOSPITAL NET FULL \$3.5 MILLION AWARD

Because Florida does not recognize common-law marriage, a \$3.5 million malpractice award to a brain-damaged Fort Lauderdale woman is leaving her unemployed immigrant mate and their six children virtually penniless and in limbo.

Their attorney received 45 percent of the amount. The rest is held in trust to care for the comatose plaintiff in the North Miami Medical Center at the rate of \$1,000 a day. "The culprit here is the law," stated the plaintiff's attorney. "We are sympathetic. The judges were sympathetic. But everyone was locked in a set of legal handcuffs."

Another Florida statute prevents the children, aged 3 to 19, from access to the trust fund as long as their mother is alive, although a court agreed to disburse \$2,500 monthly on behalf of the five minor children.

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are Director of the Department, and Director of Special Projects, respectively.

A circuit judge tried to give the family \$104,000. But, citing state law, a probate judge forced the father, an illiterate Jamaican, to pay it back.

The malpractice suit was against the Broward Medical Center where in 1985, the plaintiff's heart stopped during a caesarean section. Her baby was not damaged. The award came after 30 months of litigation. (*Medical Liability Monitor*, April 15, 1988, Volume 13, Number 4)

LIABILITY FROM EXPANDING HOME CARE PROGRAMS POSES NEW WORRIES

Home care programs are likely candidates for malpractice suits in the 1990s, the American Hospital Association has suggested.

The greatest liability risk stems from the unsupervised care provided in the increasingly popular programs. At home, there is no one to ensure the patient follows the treatment plan consistently. Without monitoring, patients may use equipment improperly, miss medications, or unplug respirators. Medical complications, such as infections, can take longer to identify.

Hospitals, which operate nearly one out of every four Medicare-certified home care programs, can be liable for such problems under theories of negligence—too early discharges, deterioration of condition—and product liability—selling defective home care products, the American Hospital Association said.

Gerald Phillips, vice-president of Alexander & Alexander, Nashville, recommends that hospital-sponsored home care programs carry their own professional liability coverage. When hospitals contract with other agencies to provide home care services, they should negotiate "hold harmless" clauses, exempting the hospital, said James Orlikoff, director of the American Hospital Association's Institute on Quality of Care and Patterns of Practice, which termed home care a future liability area. (*Medical Liability Monitor*, April 18, 1988, Volume 13, Number 4)

HOSPITAL LIABLE FOR STAFF PHYSICIAN'S OFF-PREMISES CONDUCT

Given the litigious nature of our society and soaring insurance costs, any decision that extends the scope of hospital liability deserves comment. The Massachusetts Supreme Judicial Court (SJC) has held that a hospital may be liable for a staff physician's improper conduct even though it took place outside the hospital in a patient's apartment.

The plaintiff, a former patient of a neurosurgeon who was on the visiting staff of a hospital, sued for injuries suffered when the neurosurgeon drugged and raped her. At the time of the incident, she was an employee of the same hospital.

At trial, the hospital moved for summary judgment. For purposes of the motion, the trial judge assumed that the hospital had been negligent. But, in granting the hospital's motion, the judge in effect ruled as a matter of law that its negligence had not been the proximate cause of the plaintiff's injuries.

On appeal, the SJC recast the issue as one of foreseeability. Noting that the hospital was aware of at least two prior instances in which patients of the physician had lodged formal complaints of sexual molestation,

the high court essentially decided that it was foreseeable that another instance of abuse might occur.

The general rule is that an intervening criminal act by a third party breaks the chain of proximate cause if the original wrongdoer reasonably could not have foreseen the act. Thus, the real question before the SJC was the legal limits of foreseeability. The SJC held that the judge's ruling was erroneous—the withdrawal of the physician's staff privileges (the ultimate response of which the hospital was capable) would not have prevented the rape. It accepted the plaintiff's argument that she relied on the physician's reputation and that if she had heard that his staff privileges were revoked, she would have chosen another physician.

The SJC opinion elicited two sharp dissents. Both judges argued that as a matter of law, no hospital should owe a duty of care to persons who are visited by staff physicians in their homes. In their view, if a hospital owed a duty to protect patients from physicians, it ended at the hospital door.

This decision is most disturbing. It can only serve notice on hospital administrators that in addressing allegations of physician misconduct, they should act promptly and in the direction of disciplining physicians. This may create situations in which physicians lose staff privileges before a full investigation occurs. (Philip Reilly, J.D., M.D., *Medical Liability Monitor*, June 17, 1988, Vol. 13, Number 6)

DATA ON PHYSICIAN-OWNED COMPANIES REVEALS TREMENDOUS GROWTH

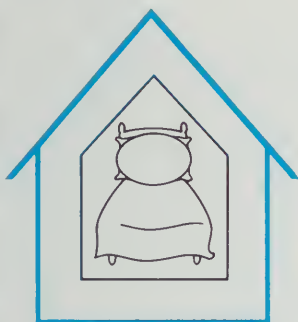
In the 1970s, they were known as the "bedpan mutuals." Today, the nation's physician-owned medical malpractice insurance companies operate in at least 40 states and the District of Columbia, insure 172,000 physicians, and write \$1,941,000,000 in annual premiums.

Data provided by 41 companies listed in the 1988 directory of the Physician Insurers Association of America (PIAA) released at the association's annual meeting in San Diego also provided insights into premium ranges around the country. The national average premium for \$1 million coverage is \$11,200. The average premium by region ranges from a low of \$10,300 in the west to \$10,400 in the central region, \$11,500 in the south, and \$13,600 in the east.

Rates for high-risk surgeons, however, can be described accurately as astronomical, particularly in Florida, New York, and Michigan. The Florida Physicians Insurance Company charges a high of \$185,000 in the Miami area and the annual premium for similar specialists in certain sections of New York state is \$115,000.

In refreshing contrast, Oklahoma's premiums are far and away the lowest in the nation. The state's occurrence rate for top-risk surgeons is \$11,900, just \$700 more than the national average for all physician classifications.

At the close of 1987, the 41 PIAA companies had an aggregate surplus of \$900 million or an amount equal to about \$5,100 per policyholder. Here again, the west leads the way with \$7,300 in surplus per policyholder compared with \$4,300 in the central region, \$3,600 in the south, and \$4,600 in the east. (*Medical Liability Monitor*, June 17, 1988, Vol. 13, Number 6)



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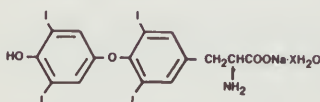
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FOR ORAL ADMINISTRATION

DESCRIPTION:

Each LEVOXINE (Levothyroxine Sodium, USP) tablet contains synthetic crystalline levothyroxine sodium (L-thyroxine). L-thyroxine is the principal hormone secreted by the normal thyroid gland. Chemically, L-thyroxine is designated as L-tyrosine, O-(4-hydroxy-3, 5-diiodophenyl) - 3,5-diiodo-, monosodium salt, hydrate. The molecular formula is $C_{15}H_{10}I_2NNaO_4$ and the structural formula is:



CLINICAL PHARMACOLOGY:

The principal effect of thyroid hormones is to increase the metabolic rate of body tissues.

The thyroid hormones are also concerned with growth and development of tissues in the young.

The major thyroid hormones are L-thyroxine (T_4) and L-triiodothyronine (T_3). The amounts of T_4 and T_3 released from the normally functioning thyroid gland are regulated by the amount of thyrotropin (TSH) secreted from the anterior pituitary gland. T_4 is the major component of normal thyroid gland excretions and is therefore the primary determinant of normal thyroid functions. T_4 acts as a substrate for physiologic deiodination to T_3 in the peripheral tissues. The physiologic effects of thyroid hormones are mediated at the cellular level primarily by T_3 .

LEVOXINE (L-thyroxine) tablets taken orally provide T_4 which upon absorption can not be distinguished from T_4 that is secreted endogenously.

INDICATIONS AND USAGE:

LEVOXINE (L-thyroxine) tablets are indicated as replacement or supplemental therapy for diminished or absent thyroid function (e.g., cretinism, myxedema, nontoxic goiter or hypothyroidism generally, including the hypothyroid state in children, in pregnancy and in the elderly) resulting from functional deficiency, primary atrophy, from partial or complete absence of the gland or from the effects of surgery, radiation or antithyroid agents. Therapy must be maintained continuously to control the symptoms of hypothyroidism.

CONTRAINDICATIONS:

L-thyroxine therapy is contraindicated in thyrotoxicosis, acute myocardial infarction and uncorrected adrenal insufficiency.

WARNINGS:

Drugs with thyroid hormone activity, alone or together with other therapeutic agents, have been used for the treatment of obesity. In euthyroid patients, doses within the range of daily hormonal requirements are ineffective for weight reduction. Larger doses may produce serious or even life-threatening manifestations of toxicity, particularly when given in association with sympathomimetic amines such as those used for their anorectic effects.

PRECAUTIONS:

General — Caution must be exercised in the administration of this drug to patients with cardiovascular disease. Development of chest pains or other aggravation of the cardiovascular disease requires a reduction of dosage.

LEVOXINE (L-thyroxine) 100 mcg (0.1 mg), 200 mcg (0.2 mg) and 300 mcg (0.3 mg) tablets contain FD & C Yellow No. 5 (tartrazine) which may cause allergic-type reactions (including bronchial asthma) in certain susceptible individuals. Although the overall incidence of FD & C Yellow No. 5 (tartrazine) sensitivity in the general population is low, it is frequently seen in patients who also have aspirin hypersensitivity.

Information For The Patient — Patients on thyroid preparations and parents of children on thyroid therapy should be informed that:

1. Replacement therapy is to be taken essentially for life, with the exception of cases of transient hypothyroidism, usually associated with thyroiditis, and in those patients receiving a therapeutic trial of the drug.
2. They should immediately report during the course of therapy any signs or symptoms of thyroid hormone toxicity, e.g., chest pain, increased pulse rate, palpitations, excessive sweating, heat intolerance, nervousness, or any other unusual event.
3. In case of concomitant diabetes mellitus, the daily dosage of antidiabetic medication may need readjustment as thyroid hormone replacement is achieved. If thyroid medication is stopped, a downward readjustment of the dosage of insulin or oral hypoglycemic agent may be necessary to avoid hypoglycemia. At all times, close monitoring of urinary glucose levels is mandatory in such patients.

4. In case of concomitant oral anticoagulant therapy, the prothrombin time should be measured frequently to determine if the dosage of oral anticoagulants is to be readjusted.

5. Partial loss of hair may be experienced by children in the first few months of thyroid therapy, but this is usually a transient phenomenon and later recovery is usually the rule.

Laboratory Tests — The patient's response to thyroid replacement may be followed by laboratory tests such as serum thyroxine (T_4), serum triiodothyronine (T_3), free thyroxine index and thyroid stimulating hormone (TSH) blood levels.

Drug Interactions — In patients with diabetes mellitus, addition of thyroid hormone therapy may cause an increase in the required dosage of insulin or oral hypoglycemic agents. Therefore, patients with diabetes mellitus should be observed closely for possible changes in antidiabetic drug dosage requirements.

Patients stabilized on oral anticoagulants who are found to require thyroid replacement therapy should be watched very closely when therapy is started. If a patient is truly hypothyroid, it is likely that a reduction in anticoagulant dosage will be required. No special precautions appear to be necessary when oral anticoagulant therapy is begun in a patient already stabilized on maintenance thyroid replacement therapy.

Cholestyramine binds both T_4 and T_3 in the intestine, thus impairing absorption of these thyroid hormones. In vitro studies indicate that the binding is not easily removed. Therefore, four to five hours should elapse between administration of cholestyramine and thyroid hormones.

Estrogens tend to increase serum thyroxine-binding globulin (TBG). In a patient with a non-functioning thyroid gland who is receiving thyroid replacement therapy, free thyroxine may be decreased when estrogens are started thus increasing thyroid requirements. However, if the patient's thyroid gland has sufficient function the decreased free thyroxine will result in a compensatory increase in thyroxine output by the thyroid. Therefore, patients without a functioning thyroid gland who are on thyroid replacement therapy may need to increase their thyroid dose if estrogens or estrogen containing oral contraceptives are given.

Drug/Laboratory Test Interactions — The following drugs or moieties are known to interfere with laboratory tests performed on patients taking thyroid hormone: androgens, corticosteroids, estrogens, oral contraceptives containing estrogens, iodine-containing preparations, and the numerous preparations containing salicylates.

1. Changes in TBG concentration should be taken into consideration in the interpretation of T_4 and T_3 values. In such cases, the unbound (free) hormone should be measured. Pregnancy, estrogens, and estrogen-containing oral contraceptives increase TBG concentrations. TBG may also be increased during infectious hepatitis. Decreases in TBG concentrations are observed in nephrosis, acromegaly, and after androgen or corticosteroid therapy. Familial hyper- or hypo-thyroxine-binding-globulinemias have been described. The incidence of TBG deficiency approximates 1 in 9000. The binding of thyroxine by thyroid-binding prealbumin (TBPA) is inhibited by salicylates.

2. Medical or dietary iodine interferences with all in vivo tests of radio-iodine uptake, producing low uptakes which may not be reflective of a true decrease in hormone synthesis.

3. The persistence of clinical and laboratory evidence of hypothyroidism in spite of adequate dosage replacement indicates either poor patient compliance, poor absorption, excessive fecal loss, or inactivity of the preparation. Intracellular resistance to thyroid hormone is quite rare.

Carcinogenesis, Mutagenesis, And Impairment Of Fertility

— A reportedly apparent association between prolonged thyroid therapy and breast cancer has not been confirmed and patients on thyroid for established indications should not discontinue therapy. No confirmatory long-term studies in animals have been performed to evaluate carcinogenic potential, mutagenicity, or impairment of fertility in either males or females.

Pregnancy — Category A — Thyroid hormones do not readily cross the placental barrier. The clinical experience to date does not indicate any adverse effect on fetuses when thyroid hormones are administered to pregnant women. On the basis of current knowledge, thyroid replacement therapy to hypothyroid women should not be discontinued during pregnancy.

Nursing Mothers — Minimal amounts of thyroid hormones are excreted in human milk. Thyroid is not associated with serious adverse reactions and does not have a known tumorigenic potential. However, caution should be exercised when thyroid is administered to a nursing woman.

Pediatric Use — Pregnant mothers provide little or no thyroid hormone to the fetus. The incidence of congenital hypothyroidism is relatively high (1:4,000) and the hypothyroid fetus would not derive any benefit from the small amounts of hormone crossing the placental barrier. Routine determinations of serum (T_4) and/or TSH is strongly advised in neonates in view of the deleterious effects of thyroid deficiency on growth and development.

Treatment should be initiated immediately upon diagnosis, and maintained for life, unless transient hypothyroidism is suspected; in which case, therapy may be interrupted for 2 to 8 weeks after the age of 3 years to reassess the condition. Cessation of therapy is justified in patients who have maintained a normal TSH during those 2 to 8 weeks.

ADVERSE REACTIONS:

Adverse reactions are due to overdosage and are those of induced hyperthyroidism.

OVERDOSAGE — Excessive dosage of thyroid medication may result in symptoms of hyperthyroidism. Since, however, the effects do not appear at once, the symptoms may not appear for one to three weeks after the dosage regimen is begun. The most common signs and symptoms of overdosage are weight loss, palpitation, nervousness, diarrhea or abdominal cramps, sweating, tachycardia, cardiac arrhythmias, angina pectoris, tremors, headache, insomnia, intolerance to heat and fever. If symptoms of overdosage appear, discontinue medication for several days and reinstitute treatment at a lower dosage level.

Laboratory tests such as serum T_4 , serum T_3 and the free thyroxine index will be elevated during the period of overdosage.

Complications as a result of the induced hypermetabolic state may include cardiac failure and death due to arrhythmia or failure.

TREATMENT OF OVERDOSAGE — Dosage should be reduced or therapy temporarily discontinued if signs and symptoms of overdosage appear. Treatment may be reinstituted at a lower dosage. In normal individuals, normal hypothalamic-pituitary-thyroid axis function is restored in 6 to 8 weeks after thyroid suppression.

Treatment of acute massive thyroid hormone overdosage is aimed at reducing gastrointestinal absorption of the drugs and counteracting central and peripheral effects, mainly those of increased sympathetic activity. Vomiting may be induced initially; if further gastrointestinal absorption can reasonably be prevented, and barring contraindications such as coma, convulsions, or loss of the gagging reflex. Treatment is symptomatic and supportive. Oxygen may be administered and ventilation maintained. Cardiac glycosides may be indicated if congestive heart failure develops. Measures to control fever, hypoglycemia, or fluid loss should be instituted if needed. Antiadrenergic agents, particularly propranolol, have been used advantageously in the treatment of increased sympathetic activity. Propranolol may be administered intravenously at a dosage of 1 to 3 mg over a 10 minute period orally, 80 to 160 mg/day, especially when no contraindications exist for its use.

DOSAGE AND ADMINISTRATION:

The goal of therapy should be the restoration of euthyroidism as judged by clinical response and confirmed by appropriate laboratory tests such as serum thyroxine (T_4), serum triiodothyronine (T_3), free thyroxine index and thyroid stimulating hormone (TSH) blood levels. The age and general condition of the patient and the severity and duration of hypothyroid symptoms determine the starting dosage and the rate of incremental dosage increase leading to a final maintenance dosage.

In otherwise healthy adults, the recommended initial dose is 25 to 100 mcg (0.025 to 0.1 mg) daily, while the predicted full maintenance dose of 100 to 200 mcg (0.1 to 0.2 mg) daily may be achieved in two to three weeks.

In the elderly patient with long standing disease, evidence of myxedema, or evidence of cardiovascular dysfunction, the initial dose may be as little as 12½ mcg (0.0125 mg) per day. Incremental increases of 25 mcg (0.025 mg) per day at 3 to 4 week intervals may be instituted depending on patient response. It is the physician's judgement of the severity of the disease and close observation of patient response which determine the rate and extent of dosage increase.

In infants and children there is a great urgency to achieve thyroid replacement because of the critical importance of thyroid hormone in sustaining growth and maturation. Despite the smaller body size, the dosage needed to sustain a full rate of growth, development and general thriving is higher in the child than in the adult. The recommended daily replacement dosage: L-thyroxine in childhood is: 0-1 years: 9 mcg/kg; 1-5 years: 6 mcg/kg; 6-10 years: 4 mcg/kg; 11-20 years: 3 mcg/kg daily.

DOSAGE FORMS AVAILABLE:

LEVOXINE (L-thyroxine) tablets are supplied as oval, color coded, potency marked tablets in 10 strengths, 12½ mcg (0.0125 mg) — maroon, 25 mcg (0.025 mg) — orange, 50 mcg (0.05 mg) — white, 75 mcg (0.075 mg) — purple, 100 mcg (0.1 mg) — yellow, 125 mcg (0.125 mg) — brown, 150 mcg (0.15 mg) — blue, 175 mcg (0.175 mg) — turquoise, 200 mcg (0.2 mg) — pink and 300 mcg (0.3 mg) — green in bottles of 100 and 1000, and unit dose in cartons of 10 (10 strips of 10 tablets).

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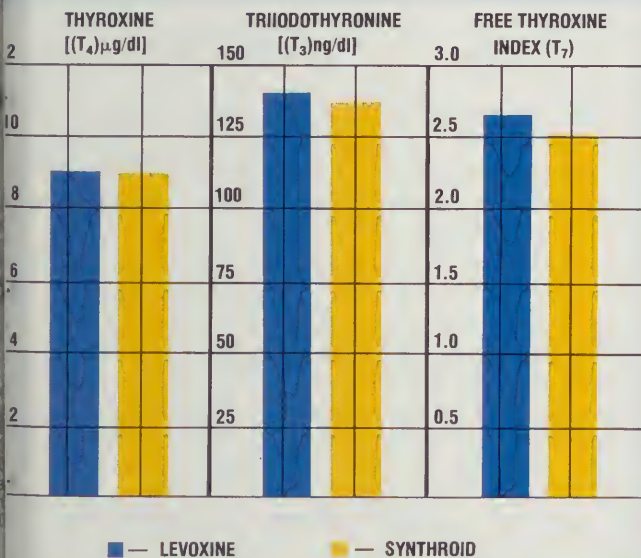
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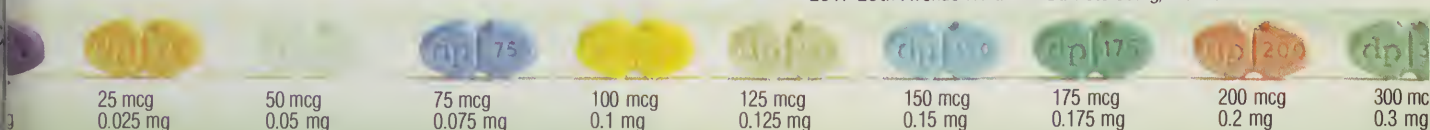
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Senior Citizens Courtesy Program

PALMA E. FORMICA, M.D.

Questions and answers about the Senior Citizens Courtesy Program.

Shortly after taking office, I wrote to each of you urging your participation in the Senior Citizens

Courtesy Program. I am pleased with the response and thank those of you for support and participation. Yet, there still appears to be some questions.

Q: What is the Seniors Courtesy Program?

A: In September 1986, the Union County Medical Society started a Senior Citizens Courtesy Program as an alternative to the Medicare participating physicians program. Working with the Senior Citizens Council of Union County, the Medical Society established a program whereby physicians voluntarily agree to accept assignment for those individuals who had a financial need. The group screens applicants and issues special "courtesy" cards. The financial eligibility is the same as for the Pharmaceutical Assistance to the Aged and Disabled Program sponsored by the state of New Jersey. Physicians volunteer to accept assignment. The MSNJ office staff serves as a referral source for those who need a physician.

The House of Delegates and the Board of Trustees of MSNJ encouraged similar programs in each of the component medical societies. To date, every county has such a program. Some work closely with senior groups or the offices on aging, others have less formal structures. Basically, the criteria for a patient to be eligible for the program is to be a PAAD cardholder, or to be within the financial limits of the PAAD program: \$13,250 annual income for a single person; or \$16,250 for a couple. (Bergen County Medical Society has established higher limits.) Physicians who voluntarily participate are asked to list their names with their local county medical society offices.

When a physician agrees to be a part of this volun-

tary program, he agrees to accept assignment for services to patients who meet the criteria or who are PAAD cardholders. By law, the physician must make an attempt to collect the \$75 deductible and the 20 percent copayment. Ironically, when a physician "wrote off" the deductible and/or the copayment routinely on all, or almost all cases, the government's fiscal intermediary (the insurance carrier) reduced that physician's profile of charges by the amount written off. The physician can determine for himself whether or not he will accept new patients.

Q: Who should participate?

A: Any physician who is not enrolled in the Medicare participating physicians program is encouraged to join. In New Jersey, 22.7 percent of physicians were enrolled in the government program in 1987. These individuals have agreed to accept assignment on all services rendered to every Medicare recipient. The Physicians Payment Review Commission has acknowledged that noneconomic and philosophical concerns affect the refusal to join the federal program. Many are reluctant to yield the freedom of decision making on billing to the government.

It is evident that most physicians have been accepting assignment on a case by case basis. In 1987, 63 percent of all claims were assigned. Since physicians always have been sensitive to the needs of their patients, this voluntary program simplifies the determination of need and eliminates the necessity of the patient having to ask for the service.

Q: Won't this voluntary program lead to mandatory assignment?

A: During the hearings on the mandatory assignment bills in the last session of the legislature, the lawmakers were impressed by the voluntary initiatives of the doctors. By providing for those in financial need, we destroy the allegations that physicians are insensitive to patients' needs. Legislators agree that if there is no need, regulation is not necessary. Using the state guidelines for the PAAD program, we are using the same criteria for establishing assistance. Although new bills have been reintroduced in the legislature by Karcher and Orechio, passage is not expected if there is implementation and continued success of the courtesy programs.

The objection, "This program will lead to Medicare mills," to the voluntary program is not founded at all. I assume the term "Medicare mill" is a duplication of the Medicaid mill where large-scale entrepreneurs advertise to accept Medicare payment and exploit the patients and the system by increasing volume and utilization and by rendering unnecessary service in a decreased time frame. If anyone is so unethical and unprofessional to be engaged in such practices, he should be reported. I hardly believe such individuals would be waiting for a voluntary program where the payments are not as high as the participation one.

Also, if each of us responds to the needs of our own, there is little need for patients to be funneled into such operations. It is a known fact that patients will not leave a physician whom they trust and like for a discounted price opportunity.

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Election Year 1988

HOWARD D. SLOBODIEN, M.D.

The July 8/15, 1988, issue of the *American Medical News* should be required reading for all who

care about the delivery of medical and health care in this country. Reportage of the actions of the House of Delegates to the AMA at the annual meeting in June occupies the bulk of the publication, but other items deserve attention. I shall not critique the work of the House; members of our delegation will attend to this. But allow me to comment on other reported items—not part of the official deliberations at the annual meeting.

AMPAC (American Medical Political Action Committee) sponsored a program called "Participation '88." Speakers included David Blumenthal, M.D., senior vice-president of the Brigham and Woman's Hospital, Boston, previously an aide to Senator Edward Kennedy and now a health advisor to Governor Dukakis; and Barbara Rockett, M.D., who "interacts" on health issues with the Bush campaign, is a practicing surgeon from Brookline, and is past-president of the Massachusetts Medical Society.

Dr. Rockett spoke of the exodus of physicians from Massachusetts and the development of alternate life-

styles, e.g., carpentry, by some who remained, but not as physicians. She discussed the four M's: Medicare, Medicaid, Malpractice, and the Miracle that patient care in Massachusetts has survived at all in light of the problems posed by the first three M's. She apparently had little to say about Vice-President Bush's health care plans.

Dr. Blumenthal noted that Massachusetts, despite the exodus, had the third highest ratio of doctors to population in the 50 states. He pointed to the "blight upon our national conscience that 37 million Americans—one third of them children—do not have any form of health insurance." The health plank of his party states, in part, "Federal coordination and leadership are necessary to contain health care costs while assuring quality care, basic insurance coverage, and advanced medical research."

Princeton University's Uwe Reinhardt, speaking to medical students at their annual luncheon, told them to get out of health care and into hula hoops if they opposed government interference in their work. According to the report in *American Medical News*, he also felt that physicians should be the ones to solve the problem of the 37 million uninsured, "to get them insured." Of course, taxes would have to be raised. Yet, he also implied that doctors should be able to allocate properly the finite sum granted them by the government and other payors, to be able to live within a budget and to see the big (macro) picture—a typical posture from one who never treated a patient and cannot be concerned with the individual (micro) person. If only these soothsayers could be compelled to shoulder their just liability in the courts!

It also is interesting to note that Dr. Reinhardt professes to know the proper percentage of the gross national product to be spent for health care, yet he seems not to know why Medicare expenditures rose more than twice as much as health expenditures for all other Americans in the last decade. But, after 1987, what can we expect from economists?

If you believe that politicians, bureaucrats, and economists know what is best for the American patient and the American physician, do nothing.

If you believe that politicians, bureaucrats, and economists do not know what's best for the American patient and the American physician, but will have their way in any event, do nothing.

But, if you believe that they do not know what is best, and that medicine is too important not to be left, for the most part, to physicians, now is the time to give careful attention to "social ethics in the political arena," as Uwe Reinhardt phrases it—but perhaps not exactly as he intends it. Now is the time for you, your family, and your friends to participate actively during this most important election year. Money helps. Working for the candidate of your choice is even better. And voting is essential.

ALLERGIC BRONCHOPULMONARY ASPERGILLOSIS: REPORT OF THREE CASES

LEONARD BIELORY, M.D., ADENIYI OGUNKOYA, M.D., ROBERT RESTIFO, D.O.,
CHRISTINE L. HOLLAND, M.D., NEWARK*

Allergic bronchopulmonary aspergillosis (ABPA) is not an uncommon complication of chronic asthma. We found the prevalence of ABPA to be 10 percent of randomly sampled asthmatic patients (inpatient and outpatient) and suggest that the prevalence of ABPA is more frequent than previously appreciated by many physicians.

Aspergillosis is a disease caused by the dimorphic fungus *Aspergillus*, whose species are ubiquitous in nature. The responsible species causing human disease almost invariably is *Aspergillus fumigatus*.¹ The spectrum of *Aspergillus* lung diseases includes primary invasive aspergillosis, mycetoma, and hypersensitivity states. We report three cases of allergic bronchopulmonary aspergillosis (ABPA) from University Hospital's Division of Allergy and Immunology, as part of an ongoing study for the evaluation of ABPA in the general asthmatic population.

METHODS

Allergic bronchopulmonary aspergillosis was diagnosed according to the criteria defined by Patterson^{2,14} which included asthma, and five of the following: peripheral blood eosinophilia, immediate skin reactivity against *A. fumigatus*, presence of precipitating antibodies to *A. fumigatus* antigen, elevated total serum IgE, specific IgE to *A. fumigatus*, and abnormal chest radiographs including pulmonary infiltrates and/or central bronchiectasis (Table).

Patients were obtained from random sampling of the general asthmatic population at UMDNJ-New Jersey Medical School/University Hospital and those asthmatic patients specifically referred for the evaluation of ABPA.

Serum total IgE levels were performed using an enzyme-linked immunoassay.^{3**} Specific serum IgE levels to *A. fumigatus* antigen were performed with the fluorometric modified radioallergosorbent test (RAST).^{**} Precipitins were performed using neat sera (unconcentrated) against several *Aspergillus* species including *A. fumigatus*, *A. niger*, and *A. flavus*.[†] The Ouchterlony plates were prepared according to the Mancini technique.^{4,5}

Epicutaneous (prick; 1:20 dilution) and intradermal (0.2 ml; 1:1000 dilution) skin tests for immediate hypersensitivity were performed with *Aspergillus* antigens from various sources (National Aspergillosis Registry Antigen, Greer Laboratories, and Center Laboratories). Prick and intradermal skin tests were applied to the volar aspect of the forearm or the lateral aspect of the upper arm. Histamine phosphate (1.0 mg histamine/ml, Eli Lilly & Co., Indianapolis, Indiana) was used as the positive control. Phenolic saline was used as the negative control. Results were determined at 15 minutes after prick and intradermal testing by taking two measurements of the reaction (wheal and

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**3M Diagnostics, California.

†Greer Laboratories, North Carolina.

TABLE
Prevalence of Clinical and
Laboratory Findings in ABPA

Criteria	Incidence in ABPA
Asthma	100%
Positive skin test	100%
Elevated IgE (> 500 IU/ml)	100%
<i>A. fumigatus</i> specific IgE	91%
Pulmonary infiltrate	80-90%*
Positive precipitins	69%**
Eosinophilia	66%
Central bronchiectasis	41%†

*Homogeneous shadows present (fleeting infiltrates).

**Incidence greater than 90 percent when serum is concentrated threefold to fourfold.

†41 percent found in this series as a permanent finding.

flare), the longest diameter, and at 90 degrees to the longest diameter.

CASE REPORT 1

A 24-year-old black male, with a history of asthma since age 3, had multiple exacerbations requiring emergency room visits and hospital admissions to UMDNJ-University Hospital. Precipitating factors of his asthma include warm weather, exposure to dusts, and upper respiratory infections. The patient denied aspirin sensitivity, and does not smoke, consume alcohol, or use illicit drugs. The patient's mother, brother, sister, and daughter have asthma. Current medications included: theophylline (Theo-Dur®) 300 mg three times a day, metaproterenol (Alupent®) metered-dose inhaler (2 inhalations) four times a day, and prednisone (Deltasone®) 10 mg daily. Physical examination revealed bilateral expiratory wheezes.

The laboratory examination revealed IgE of 799 IU/ml, eosinophil count of 328 cells/ml (on steroids), positive *A. fumigatus* immediate skin test, positive precipitins, and positive *A. fumigatus* specific IgE. The chest radiograph revealed central bronchiectasis and infiltrates. Pulmonary function tests revealed severe airway obstruction with significant response to bronchodilators, with a minimal restrictive defect. The patient presently is controlled with steroids and bronchodilators. No followup IgE level has been obtained.

CASE REPORT 2

A 7-year-old Hispanic male had a history of asthma since six months of age exacerbated by dusts, exercise, pollens, and aeroallergens. The patient's family denied drug hypersensitivity including aspirin. He was referred to the Division of Allergy and Immunology for the evaluation of ABPA; he had an elevated IgE level and x-ray evidence of central bronchiectasis. Family members with asthma and allergies include maternal relatives, two brothers, and four sisters. Current medications included theophylline (Slo-bid™) 300 mg daily, and prednisone (Deltasone®) 5 mg daily. Auscultation of the chest did not reveal any wheezing.

The laboratory examination revealed IgE of 2207 IU/ml, eosinophil count of 330 cells/ml (on steroids), positive *A. fumigatus* immediate skin test, positive precipitins, and positive *A. fumigatus* specific IgE. The sweat chloride measurement was <15 mEq/L (levels >60 mEq/L indicate cystic fibrosis). The chest radiograph revealed central bronchiectasis. The patient was continued on his usual bronchodilator regimen while steroids were increased to a dose of 0.5 mg/kg/day for two months and then switched to an alternate day regimen. Three months later, the patient was asymptomatic with the serum IgE level falling to 78.5 IU/ml.

CASE REPORT 3

A 25-year-old black male had a history of asthma since childhood and suffered multiple exacerbations requiring hospitalizations. Symptoms were exacerbated by exposure to dusty environments, warm humid weather, grasses, and upper respiratory infections. The patient had a history of allergies to pollen, grasses, and dust. He denied drug allergies or aspirin sensitivity. The patient's mother and brother have asthma. The patient smokes one pack of cigarettes per day, occasionally consumes alcohol, and uses intranasal cocaine. Physical examination revealed mild expiratory wheezes. Medications included theophylline (Theo-Dur®) 900 mg daily, metaproterenol (Alupent®) metered-dose inhaler (two inhalations) four times a day, and prednisone (Deltasone®) 10 mg daily.

The laboratory examination revealed IgE of 3534 IU/ml, eosinophil count of 405 cells/ml (on steroids), positive *A. fumigatus* immediate skin test, positive precipitins, and positive *A. fumigatus* specific IgE. An old chest radiograph revealed a right upper lobe infiltrate which resolved and then recurred two years later. The patient continued his usual regimen of bronchodilators, and prednisone (0.5 mg/kg/day) was prescribed. The IgE level fell to 389 IU/ml after four weeks of treatment with clinical resolution of his wheezing.

DISCUSSION

Allergic bronchopulmonary aspergillosis now has been recognized as a complication of asthma. It first was described in 1952 in asthmatics of the United Kingdom⁶ and then in the United States in 1968. The incidence of ABPA in the original study in the United Kingdom was 22 percent, but 9 percent in steroid-dependent asthmatics of North America.⁷ The incidence of ABPA has been reported to be unknown in unselected populations of asthmatics.⁸ An ongoing study by the Division of Allergy and Immunology at UMDNJ-University Hospital, has shown that in a series of 20 randomly selected asthmatics followed in the hospital and clinic setting, 10 percent met the criteria for the diagnosis of ABPA while an increased prevalence of 70 percent was noted in asthmatic patients (n=10) specifically referred for the evaluation of suspected ABPA.⁹ These statistics reflect a higher incidence than previously suspected, and physicians evaluating recalcitrant asthmatic patients or practicing in other inner-city settings should consider this diagnosis when appropriate.

Hypersensitive IgE-mediated pulmonary disorders associated with *Aspergillus* or *Candida* are unique in terms of the inflammatory response. The fungus actu-

ally colonizes and grows into the surrounding pulmonary tissue which subsequently generates a cell-mediated and humoral (IgE and IgG) immunological response.¹⁰ The monitoring of IgE levels in ABPA patients may be a helpful predictor of disease activity: rising IgE levels are very indicative of a flare, whereas a stable or decreasing value implicates disease remission as exemplified in case reports 2 and 3.¹⁰

The diagnostic criteria for ABPA and the prevalence of these clinical findings, as found in other studies, were similar to those found in our study (Table).^{2,8,9,14-16} In our patients, the most significant of the criteria for the diagnosis of ABPA was the immediate sensitivity to *A. fumigatus* antigen, as our patients with ABPA uniformly have a positive, immediate (wheal and flare) reaction to *Aspergillus*. A nonreactive test virtually excludes the diagnosis. All three patients had positive immediate hypersensitivity skin tests. They also had elevated IgE level (799, 3534, and 2207 IU/ml) and specific IgE and positive precipitins, but only two of the patients had central bronchiectasis. Total eosinophil counts were misleading since many of the patients were on glucocorticosteroids which physiologically lower the level of circulating eosinophils.

Some of the discrepancies in the estimates of the incidence of ABPA in asthmatic populations are due to antigen selection and the lack of standardization of *A. fumigatus* antigen for clinical testing. It has been shown that commercially prepared antigen often did not induce positive skin tests and serum precipitating antibodies in patients with ABPA.¹² At the present time, there is a National Aspergillosis Registry for the evaluation and standardization of such an antigen in which our group at the Division of Allergy and Immunology of the New Jersey Medical School is participating.

Another diagnostic criteria has been the presence of serum precipitating antibodies to *Aspergillus*. They are present in approximately 50 percent of ABPA patients when the serum is tested in a neat (unconcentrated) form and in 92 percent of ABPA patients when the serum is concentrated. However, serum precipitins are not specific for ABPA.¹³

A practical approach to the diagnosis of ABPA in difficult-to-manage asthmatics without bronchiectasis is to perform an adequate *A. fumigatus* antigen immediate skin test. If the skin test is negative, then one should consider an alternate diagnosis. If the skin test is positive, then a total IgE level, specific *A. fumigatus*, IgE (RAST), and *A. fumigatus* precipitins should be obtained. The presence of an elevated IgE with the presence of specific antibodies, IgG (precipitin) and/or IgE (RAST), is highly suggestive that the patient has ABPA and would be classified as ABPA-S, i.e. bronchiectasis is absent but clinical and serologic features of ABPA are consistent with its diagnosis.¹⁴

We recommend that a panel of *A. fumigatus* antigens from various sources be used for immediate cutaneous testing in patients with suspected ABPA since it is apparent from our studies that not all commercial *Aspergillus* extracts contact the same antigens.

SUMMARY

Allergic bronchopulmonary aspergillosis is found in approximately 9 to 22 percent of steroid-dependent

asthmatics depending on site of population. All of our patients have a positive immediate (IgE-mediated) skin test and satisfied the criteria of ABPA.

The current recommendations for treatment include the use of prednisone 0.5 mg/kg/day for two weeks then alternate day therapy at the same dose for three to six months. Total IgE levels should be obtained monthly and a chest roentgenograph should be obtained every three months for the first year. Exacerbations can be detected by the doubling of the IgE level and/or appearance of chest roentgenographic infiltrate.

CONCLUSION

It is hoped that this review will result in the earlier diagnosis of ABPA and the immediate initiation of appropriate medical therapy that includes glucocorticosteroids. Intervention at an earlier stage may reduce the associated long-term sequelae such as bronchiectasis, interstitial lung disease, and chronic obstructive pulmonary disease.

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CONTRAINDICATIONS: THEO-DUR is contraindicated in individuals who have shown hypersensitivity to theophylline or any of the tablet components.

WARNINGS: Status asthmaticus should be considered a medical emergency and is defined as that degree of bronchospasm which is not rapidly responsive to usual doses of conventional bronchodilators. Optimal therapy for such patients frequently requires both *additional medication*, parenterally administered, and *close monitoring*, preferably in an intensive care setting.

Although increasing the dose of theophylline may bring about relief, such treatment may be associated with toxicity. The likelihood of such toxicity developing increases significantly when the serum theophylline concentration exceeds 20 mcg/ml. Therefore, determination of serum theophylline levels is recommended to assure maximal benefit without excessive risk.

Serum levels above 20 mcg/ml are rarely found after appropriate administration of recommended doses. However, in individuals in whom theophylline plasma clearance is reduced for any reason, even conventional doses may result in increased serum levels and potential toxicity. Reduced theophylline clearance has been documented in the following readily identifiable groups: 1) patients with impaired renal or liver function; 2) patients over 55 years of age, particularly males and those with chronic lung disease; 3) those with cardiac failure from any cause; 4) neonates; and 5) those patients taking certain drugs (macrolide antibiotics and cimetidine). Decreased clearance of theophylline may be associated with either influenza immunization or active infection with influenza.

Reduction of dosage and laboratory monitoring is especially appropriate in the above individuals. Less serious signs of theophylline toxicity (i.e. nausea and restlessness) may occur frequently when initiating therapy, but are usually transient, when such signs are persistent during maintenance therapy, they are often associated with serum concentrations above 20 mcg/ml. Unfortunately, however, serious side effects such as ventricular arrhythmias, convulsions or even death may appear as the first sign of toxicity without any previous warning. Stated differently: *serious toxicity is not reliably preceded by less severe side effects.*

Many patients who require theophylline may exhibit tachycardia due to their underlying disease process so that the cause/effect relationship to elevated serum theophylline concentrations may not be appreciated.

Theophylline products may cause dysrhythmia and/or worsen pre-existing arrhythmias and any significant change in rate and/or rhythm warrants monitoring and further investigation.

The occurrence of arrhythmias and sudden death (with histological evidence of necrosis of the myocardium) has been recorded in laboratory animals (minipigs, rodents and dogs) when theophylline and beta agonists were administered concomitantly, although not when either was administered alone. The significance of these findings when applied to human usage is currently unknown.

PRECAUTIONS: THEO-DUR TABLETS SHOULD NOT BE CHEWED OR CRUSHED.

General: Theophylline half-life is shorter in smokers than in non-smokers. Therefore, smokers may require larger or more frequent doses. Morphine and curare should be used with caution in patients with airway obstruction as they may suppress respiration and stimulate histamine release. Alternative drugs should be used when possible. Theophylline should not be administered concurrently with other xanthine medications. Use with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, in the elderly (especially males) and in neonates. In particular, great caution should be used in giving theophylline to patients with congestive heart failure. Frequently, such patients have markedly prolonged theophylline serum levels with theophylline persisting in serum for long periods following discontinuation of the drug. Individuals who are rapid metabolizers of theophylline, such as the young, smokers, and some non-smoking adults, may not be suitable candidates for once-daily dosing. These individuals will generally need to be dosed at 12 hour or sometimes 8 hour intervals. Such patients may exhibit symptoms of bronchospasm near the end of a dosing interval, or may have wider peak-to-trough differences than desired.

Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to the G.I. tract although gastrointestinal symptoms are more commonly centrally mediated and associated with serum drug concentrations over 20 mcg/ml.

Information for Patients: The physician should reinforce the importance of taking only the prescribed dose and time interval between doses. THEO-DUR tablets should not be chewed or crushed. When dosing THEO-DUR on a once daily (q24h) basis, tablets should be taken whole and not split. As with any controlled-release theophylline product, the patient should alert the physician if symptoms occur repeatedly, especially near the end of the dosing interval.

DRUG INTERACTIONS: Drug-Drug: Toxic synergism with epinephrine has been documented and may occur with some other sympathomimetic bronchodilators. In addition, the following drug interactions have been demonstrated:

Drug	Effect
Theophylline with lithium carbonate	Increased excretion of lithium carbonate
Theophylline with propranolol	Antagonism of propranolol effect
Theophylline with cimetidine	Increased theophylline blood levels
Theophylline with troleandomycin, erythromycin	Increased theophylline blood levels

Drug-Food: THEO-DUR 100 mg Sustained Action Tablets have not been adequately studied to determine whether their bioavailability is altered when given with food. Available data suggest that drug administration at the time of food ingestion may influence the absorption characteristics of theophylline controlled-release products resulting in serum values different from those found after administration in the fasting state.

A drug-food effect, if any, would likely have its greatest clinical significance when high theophylline serum levels are being maintained and/or when large single doses (greater than 13 mg/kg or 900 mg) of a controlled-release theophylline product are given.

THEO-DUR (200, 300, and 450 mg) Sustained Action Tablets: The rate and extent of absorption of theophylline from THEO-DUR 200 mg, 300 mg, and 450 mg tablets when administered fasting or immediately after a moderately high fat content breakfast is similar.

Drug-Laboratory Test Interactions: When plasma levels of theophylline are measured by spectrophotometric methods, coffee, tea, cola beverages, chocolate, and acetaminophen contribute falsely high values.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic potential, mutagenic potential, or the effect on fertility of xanthine compounds.

Pregnancy: Category C—Animal reproduction studies have not been conducted with theophylline. It is not known whether theophylline can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Xanthines should be given to a pregnant woman only if clearly needed.

Nursing Mothers: It has been reported that theophylline distributes readily into breast milk and may cause adverse effects in the infant. Caution must be used if prescribing xanthine to a mother who is nursing, taking into account the risk-benefit of this therapy.

Pediatric Use: Safety and effectiveness of THEO-DUR administered:

1. Every 24 hours in children under 12 years of age, have not been established.
2. Every 12 hours in children under 6 years of age, have not been established.

ADVERSE REACTIONS: The most consistent adverse reactions are usually due to overdose and are:

1. **Gastrointestinal:** nausea, vomiting, epigastric pain, hematemesis, diarrhea.
2. **Central nervous system:** headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions.
3. **Cardiovascular:** palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias.

4. **Respiratory:** tachypnea.
5. **Renal:** albuminuria, increased excretion of renal tubular and red blood cells, potentiation of diuresis.

Other: rash, hyperglycemia and inappropriate AOH syndrome.

OVERDOSSAGE: Management: If potential oral overdose is established and seizure has not occurred:

- A. Induce vomiting.
 - B. Administer a cathartic (this is particularly important if sustained-release preparations have been taken).
 - C. Administer activated charcoal.
- If patient is having a seizure:
- A. Establish an airway.
 - B. Administer oxygen.
 - C. Treat the seizure with intravenous diazepam, 0.1 to 0.3 mg/kg up to 10 mg.
 - D. Monitor vital signs, maintain blood pressure and provide adequate hydration.

Post Seizure Care:

- A. Maintain airway and oxygenation.
- B. If a result of oral medication, follow above recommendations to prevent absorption of the drug, but intubation and lavage will have to be performed instead of inducing emesis, and the cathartic and charcoal will need to be introduced via a large bore gastric lavage tube.
- C. Continue to provide full supportive care and adequate hydration while waiting for drug to be metabolized. In general, the drug is metabolized sufficiently rapid so as not to warrant consideration of dialysis; however, if serum levels exceed 50 mcg/ml charcoal hemoperfusion may be indicated.

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LIMITING TREATMENT: A GUIDE FOR THE PERPLEXED

MICHAEL A. NEVINS, M.D., RIVER VALE*

Decisions to withdraw or withhold medical treatment combine medical, ethical, and legal dimensions. Guidelines are provided that enunciate general principles of decision making, specific questions that should be addressed, and a medical-legal framework based on court decisions in New Jersey.

Deciding to withhold or withdraw medical treatment is never easy, nor should it be. Nonetheless, recent events suggest that many clinicians are perturbed about how to proceed when beset simultaneously by medical, moral, and legal questions that often lack clear answers.

Consider the following terse three line progress note written by an otolaryngology resident in the chart of a mentally competent patient with advanced laryngeal cancer: "Patient refused bronchoscopy. Haldol® given. Administrative consent obtained."

The Hippocratic oath calls for physicians to do what, in their opinion, would benefit the patient—but this can be carried too far! When patients disagree with us, are they necessarily crazy?

A different form of medical paternalism was displayed in the infamous "Debbie affair" reported first in the *Journal of the American Medical Association*, and later in newspapers and magazines throughout the country.¹ An obstetrics/gynecology resident administered a lethal dose of morphine to a woman dying of metastatic cancer whom he had never seen before in order to end the patient's suffering. Is it permissible to take the law into our own hands, so long as we are acting compassionately in what we believe to be a patient's best interests?

Consider still another scenario in New Jersey—a

competent woman with endstage amyotrophic lateral sclerosis (ALS) lives at home, has been on a respirator and feeding tube for three years, and is competent and communicative by eye blink. She asks that the respirator be turned off; the family concurs and two psychiatrists agree that she understands the consequences of what she is requesting. Only a few months before, the Supreme Court of New Jersey, in virtually identical circumstances in the Kathleen Farrell case, had declared that it was a legally permissible option to terminate all forms of life support.² Yet, the responsible physician refuses to comply with the patient's request, withdraws from the case, and 23 other physicians decline to become involved in the final management. No doubt, some had legitimate reasons and, admittedly, there is a fine line between active and passive euthanasia here, but many just did not want to get involved out of fear of legal entanglement. Even the explicit backing of New Jersey's Supreme Court was insufficient to overcome their anxieties.

These three anecdotes indicate that something is seriously amiss! Too often decisions are being made

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TABLE 1

General Principles Regarding Limited Treatment***1. Treatment Goals**

a. There is no obligation to provide medical care where intervention is determined by a physician to be nonbeneficial in that

- I) it would be virtually futile and unlikely to improve the patient's prognosis or
- II) the burdens to the patient that would result from the treatment substantially outweigh its potential benefits.

b. It is appropriate to withhold or remove enteral or parenteral nutrition or hydration from irreversibly ill patients according to the same criteria employed to determine the rejection of other life-saving or sustaining treatments such as mechanical respiratory support. Of course, there continues to be a firm obligation to provide adequate comfort care during this period.

c. Imminent death is not the only situation in which comfort-oriented care is ethical; other important considerations are the presence of severe physical pain or the reasonable certainty of permanent loss of those qualities that generally are thought to constitute human personhood.

2. MD-Patient Relationship

a. The freedom to choose or to reject life-sustaining medical care emanates from the constitutional right of privacy; a competent individual has the legal right to make what some people might consider to be the "wrong" decision.

b. Treatment decisions on behalf of the incompetent hopelessly ill should be made according to the best available evidence of what the patient's preferences would be if he or she were competent. If there is no such evidence, decisions should be based upon assessments of the patient's "best interests."

c. Personal medical decisions of irreversibly ill patients or their surrogates should not be subjected to public scrutiny except in the rare case that intervention is necessary to reconcile the views of the parties involved. Family members are presumed to be appropriate surrogate decision makers for patients diagnosed as being incapable of giving informed consent. If this presumption is rebutted for any reason, such as a conflict of opinion between two close relatives or evidence of prior familial neglect, then it is appropriate to seek guidance or consultation from others, but only in cases of irreconcilable conflict.

3. Special Considerations

a. Whereas these principles are universally applicable, the processes of decision making similarly should be substantially independent of the venue of treatment, lest decisions about where care is rendered are made inappropriately on the basis of procedural issues rather than on the basis of what is in the patient's best interest. The process itself should not impose undue additional burden on patient and/or family.

b. Institutional policy that usurps an individual's right to decline any form of medical care abrogates the fundamental autonomy of patients.

c. Wise decision making requires reasonable flexibility and a certain discretionary space that must be preserved, lest the physician's clinical skills be severely compromised. The prolonged time frame of judicial review and the inevitable recourse to rigid formulae by government agencies make them unsuited as participants in what necessarily is an uncertain and changing decision-making process in "the crucible of the bedside."

*Statement approved by NJ-ACP Chapter Council, Oct. 16, 1986.

TABLE 2

**Elements To Be Addressed When
Contemplating Limited Treatment**

1. Is the patient completely or partially capable of participating in decision making? If not, what is the incapacity that precludes participation?

2. What is the patient's wish (general and/or specific)? Is there any reason to believe that it has been coerced or reflects pathologic depression?

3. Is there written evidence of patient's wishes? If yes, it should be included in the medical record. If the evidence is only oral, nonetheless it too should be reported in the record. How current is the patient's expression? How explicit? How applicable to the present circumstances? How clear and convincing?

4. Has the patient expressed an opinion regarding such specific forms of treatment as resuscitation (DNR), intubation, use of a respirator, artificial feeding, dialysis, surgery, or other forms of treatment? If so, these details also should be recorded in the chart.

5. If the patient is incapable of participating in decision making, have they legally designated a surrogate? If not, who speaks for the patient and to what extent are they familiar with the patient's wishes?

6. Is there any reasonable evidence of conflict of interest, family discord, or an irreconcilable disagreement between the treating health team and patient/family? If so, would consultation with an ethics committee or another individual or group be helpful?

7. What are the major medical conditions? Does the patient suffer from an incurable and inevitably fatal disease? Is the condition "terminal" or is death imminent regardless of medical treatment? Is the patient suffering refractory pain? Is the patient permanently unconscious? Is there irreversible organ failure?

8. Has sufficient time elapsed and appropriate consultation been obtained to be reasonably certain both of the diagnosis and prognosis?

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Incompetent severely disabled, some limited respon- siveness	Yes	—	"Subjective test"—some probitive evidence of patient choice.	Same as above but life expectancy one year or less even with Rx.	
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LIMITING TREATMENT: A GUIDE FOR THE PERPLEXED

MICHAEL A. NEVINS, M.D., RIVER VALE*

Decisions to withdraw or withhold medical treatment combine medical, ethical, and legal dimensions. Guidelines are provided that enunciate general principles of decision making, specific questions that should be addressed, and a medical-legal framework based on court decisions in New Jersey.

Deciding to withhold or withdraw medical treatment is never easy, nor should it be. Nonetheless, recent events suggest that many clinicians are perturbed about how to proceed when beset simultaneously by medical, moral, and legal questions that often lack clear answers.

Consider the following terse three line progress note written by an otolaryngology resident in the chart of a mentally competent patient with advanced laryngeal cancer: "Patient refused bronchoscopy. Haldol® given. Administrative consent obtained."

The Hippocratic oath calls for physicians to do what, in their opinion, would benefit the patient—but this can be carried too far! When patients disagree with us, are they necessarily crazy?

A different form of medical paternalism was displayed in the infamous "Debbie affair" reported first in the *Journal of the American Medical Association*, and later in newspapers and magazines throughout the country.¹ An obstetrics/gynecology resident administered a lethal dose of morphine to a woman dying of metastatic cancer whom he had never seen before in order to end the patient's suffering. Is it permissible to take the law into our own hands, so long as we are acting compassionately in what we believe to be a patient's best interests?

Consider still another scenario in New Jersey—a

competent woman with endstage amyotrophic lateral sclerosis (ALS) lives at home, has been on a respirator and feeding tube for three years, and is competent and communicative by eye blink. She asks that the respirator be turned off; the family concurs and two psychiatrists agree that she understands the consequences of what she is requesting. Only a few months before, the Supreme Court of New Jersey, in virtually identical circumstances in the Kathleen Farrell case, had declared that it was a legally permissible option to terminate all forms of life support.² Yet, the responsible physician refuses to comply with the patient's request, withdraws from the case, and 23 other physicians decline to become involved in the final management. No doubt, some had legitimate reasons and, admittedly, there is a fine line between active and passive euthanasia here, but many just did not want to get involved out of fear of legal entanglement. Even the explicit backing of New Jersey's Supreme Court was insufficient to overcome their anxieties.

These three anecdotes indicate that something is seriously amiss! Too often decisions are being made

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TABLE 1

General Principles Regarding Limited Treatment***1. Treatment Goals**

a. There is no obligation to provide medical care where intervention is determined by a physician to be nonbeneficial in that

- I) it would be virtually futile and unlikely to improve the patient's prognosis or
- II) the burdens to the patient that would result from the treatment substantially outweigh its potential benefits.

b. It is appropriate to withhold or remove enteral or parenteral nutrition or hydration from irreversibly ill patients according to the same criteria employed to determine the rejection of other life-saving or sustaining treatments such as mechanical respiratory support. Of course, there continues to be a firm obligation to provide adequate comfort care during this period.

c. Imminent death is not the only situation in which comfort-oriented care is ethical; other important considerations are the presence of severe physical pain or the reasonable certainty of permanent loss of those qualities that generally are thought to constitute human personhood.

2. MD-Patient Relationship

a. The freedom to choose or to reject life-sustaining medical care emanates from the constitutional right of privacy; a competent individual has the legal right to make what some people might consider to be the "wrong" decision.

b. Treatment decisions on behalf of the incompetent hopelessly ill should be made according to the best available evidence of what the patient's preferences would be if he or she were competent. If there is no such evidence, decisions should be based upon assessments of the patient's "best interests."

c. Personal medical decisions of irreversibly ill patients or their surrogates should not be subjected to public scrutiny except in the rare case that intervention is necessary to reconcile the views of the parties involved. Family members are presumed to be appropriate surrogate decision makers for patients diagnosed as being incapable of giving informed consent. If this presumption is rebutted for any reason, such as a conflict of opinion between two close relatives or evidence of prior familial neglect, then it is appropriate to seek guidance or consultation from others, but only in cases of irreconcilable conflict.

3. Special Considerations

a. Whereas these principles are universally applicable, the processes of decision making similarly should be substantially independent of the venue of treatment, lest decisions about where care is rendered are made inappropriately on the basis of procedural issues rather than on the basis of what is in the patient's best interest. The process itself should not impose undue additional burden on patient and/or family.

b. Institutional policy that usurps an individual's right to decline any form of medical care abrogates the fundamental autonomy of patients.

c. Wise decision making requires reasonable flexibility and a certain discretionary space that must be preserved, lest the physician's clinical skills be severely compromised. The prolonged time frame of judicial review and the inevitable recourse to rigid formulae by government agencies make them unsuited as participants in what necessarily is an uncertain and changing decision-making process in "the crucible of the bedside."

*Statement approved by NJ-ACP Chapter Council, Oct. 16, 1986.

TABLE 2

Elements To Be Addressed When Contemplating Limited Treatment

1. Is the patient completely or partially capable of participating in decision making? If not, what is the incapacity that precludes participation?

2. What is the patient's wish (general and/or specific)? Is there any reason to believe that it has been coerced or reflects pathologic depression?

3. Is there written evidence of patient's wishes? If yes, it should be included in the medical record. If the evidence is only oral, nonetheless it too should be reported in the record. How current is the patient's expression? How explicit? How applicable to the present circumstances? How clear and convincing?

4. Has the patient expressed an opinion regarding such specific forms of treatment as resuscitation (DNR), intubation, use of a respirator, artificial feeding, dialysis, surgery, or other forms of treatment? If so, these details also should be recorded in the chart.

5. If the patient is incapable of participating in decision making, have they legally designated a surrogate? If not, who speaks for the patient and to what extent are they familiar with the patient's wishes?

6. Is there any reasonable evidence of conflict of interest, family discord, or an irreconcilable disagreement between the treating health team and patient/family? If so, would consultation with an ethics committee or another individual or group be helpful?

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Why Wait?



In the depressed and anxious patient

See Improvement

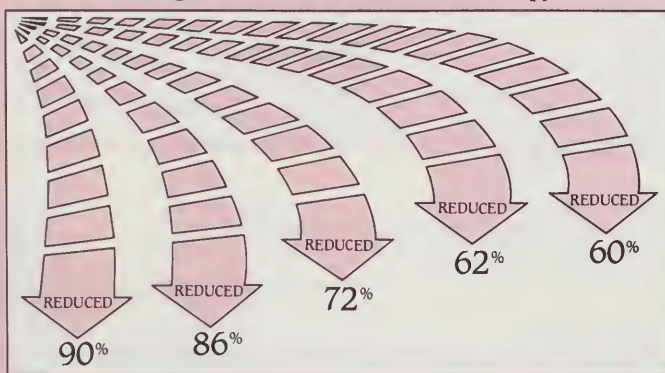


In The First Week¹...

And The Weeks That Follow

- ➡ 74% of patients experienced improved sleep after the first *h.s.* dose¹
- ➡ First-week reduction in somatic symptoms¹

Percentage of Reduction in Individual Somatic Symptoms During First Week of Limbitrol Therapy*



VOMITING NAUSEA HEADACHE ANOREXIA CONSTIPATION

*Patients often presented with more than one somatic symptom.

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Limbitrol[®] DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) (IV)

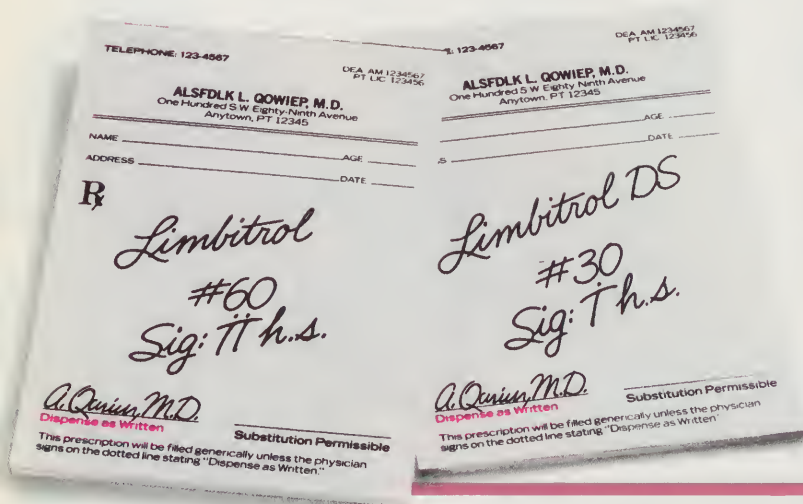
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Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

Please see references and summary of product information on following page.

In moderate depression and anxiety

- ➡ 74% of patients experienced improved sleep after the first h.s. dose¹
- ➡ First-week improvement in somatic symptoms
- ➡ 50% greater improvement with Limbitrol in the first week than with amitriptyline alone²



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Specify "Do not substitute."

Limbitrol®

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) ④

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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner VP, et al: *Psychopharmacology* 61:217-225, Mar 22, 1979.

Limbitrol® ④

Tranquillizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Use in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components closely related drugs: **Cardiovascular:** Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. **Psychiatric:** Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. **logic:** Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, ext. pyramidal symptoms, syncope, changes in EEG patterns. **Anticholinergic:** Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. **Allergic:** Skin urticaria, photosensitization, edema of face and tongue, pruritus. **Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. **Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, dry tongue. **Endocrine:** Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. **Other:** Head weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe after excessive doses over extended periods; milder after taking continuously at the levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dose. Carefully supervise addiction-prone individuals because of predisposition to habituation/dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

How Supplied: Double strength (DS) Tablets, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and Tablets, blue-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.



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CASE REPORT: CALCIFYING APONEUROTIC FIBROMA

ANIS F. RANGWALA, M.D., ROBERT BATEYKO, M.D., MARGARET SACCO, M.D.,
CYRIL ARVANITIS, M.D., LONG BRANCH

Calcifying aponeurotic fibroma is an uncommon lesion found on the hands and feet of young children. Though the lesion is known to recur, minimal surgical interference is recommended. A case report highlights this lesion with an unusual histological finding occurring on the abdominal wall of an eight-year-old girl.

In 1953, Keasbey reported a lesion characterized by proliferation of connective tissue cells with foci of calcification and varying degrees of chondroid differentiation.¹ She called this lesion juvenile aponeurotic fibroma, stressing its appearance in young children and tendency for recurrence after surgical excision probably associated with its poorly margined and infiltrative growth pattern.

Most of the cases reported have involved hands and feet.² Goldman reported one of seven cases in the abdominal wall.³ We present a second case of this lesion in the abdominal wall with an unusual histological finding.

CASE REPORT

An eight-year-old white female noticed a 2 cm painless lump on the left side of her abdomen. The mass was not fixed to the skin and had not increased in size for two months. There was no history of trauma, no recent infections, and no travel outside the United States. No other masses were detected. Past medical history noted a left inguinal herniorrhaphy four years prior to admission. Physical examination revealed a firm 2 x 1.5 cm mass in the subcutaneous tissue lateral to the left rectus abdominis muscle between the left costal margin and the umbilicus. The mass was freely movable and there was no change in the over-

lying skin. A small scar from the hernia repair was present.

At operation, a 2 x 1.4 x 3 cm irregular firm mass was excised from the rectus abdominis fascia lateral to the left rectus muscle. The mass was located within the fatty subcutaneous tissue and was noted to be infiltrating the rectus fascia. The mass was totally excised along with portions of adjacent muscle tissue and fascia. On cross-section, the mass had a gritty character. The skin and subcutaneous tissue were closed. Four months postoperatively the patient had no recurrence.

Microscopical examination showed the lesion to be unencapsulated (Figure 1), and characterized by diffuse proliferation of fibroblast-like elements that extended into surrounding adipose tissue and skeletal muscle. The spindle-shaped cells were more plump and less mature-looking than those seen in other varieties of fibromatosis, and mitotic figures were fewer than one per ten high-power fields. These cells were arranged in palisading pattern. There were multiple, centrally located foci of calcification and chondroid dif-

*From Monmouth Medical Center where Dr. Rangwala is attending pathologist, Dr. Bateyko is a resident in pathology, Dr. Sacco is a resident in surgery, and Dr. Arvanitis is director of surgery. Correspondence may be addressed to Dr. Rangwala, Department of Pathology, Monmouth Medical Center, Long Branch, NJ 07740.

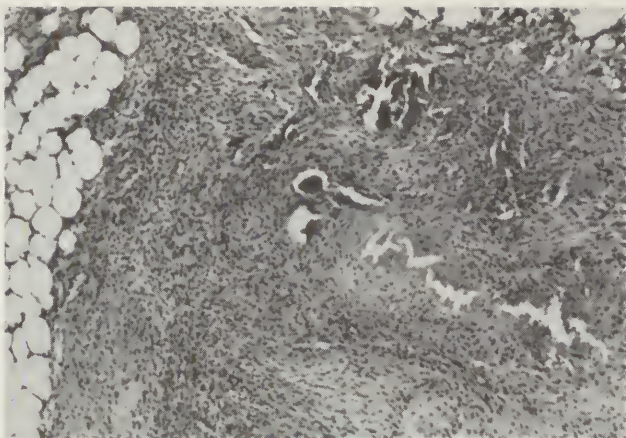


Figure 1—An uncircumscribed lesion composed of diffuse proliferation of spindle-shaped cells with focal calcification (hematoxylin and eosin stain, 10x).

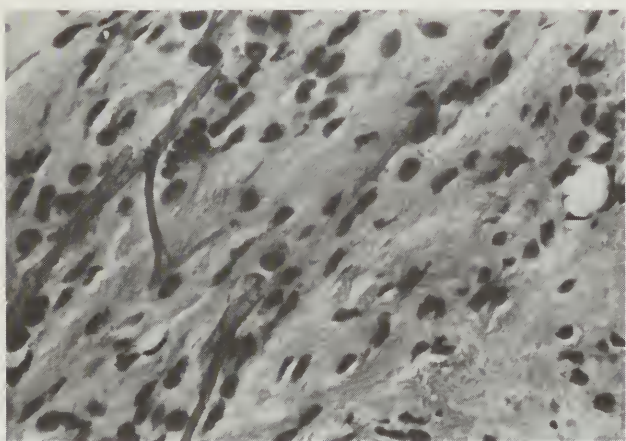


Figure 2—High-power view of calcifying aponeurotic fibroma showing irregularly branched structures (hematoxylin and eosin stain, 40x).

ferentiation. Multinucleated giant cells were seen in the regions of calcification. An unusual feature was irregularly branched structures vaguely resembling fungal mycelia which stained with elastic stain (Figure 2). (To our knowledge, this latter feature previously has not been described.)

DISCUSSION

Calcifying aponeurotic fibroma is an uncommon lesion usually found on the palms and soles, but also reported in other sites.¹⁻⁷ In 1970, Goldman found an isolated case in the lumbar paravertebral area, and in his own series of seven cases, he also found two additional cases, one case in the neck and the other case in the abdominal wall.

The terminology of this tumor has been controversial. Lichtenstein and Goldman suggested that this tumor be called cartilage analogue of fibromatosis,⁶ based on the concept that in the tumor's late phase, there is prominent degree of calcification and cartilage formation. Keasbey and Fanselau originally named the tumor juvenile aponeurotic fibroma⁸, but changed the term to aponeurotic fibroma because the tumor was not exclusively confined to children. Later, this term was modified further by Iwasaki and Enjoji

to calcifying aponeurotic fibroma,⁹ a term also preferred by Enzinger and Weiss.¹⁰

The majority of cases appear in young children, with an average age of 12 years. However, occasional cases have been reported in the elderly; the oldest patient being 64 years old.³ There appears to be a slight male predominance,² and there is no indication of familial tendency.

The tumor usually is poorly circumscribed and rarely greater than 3 cm in diameter. There is approximately a 50 percent recurrence rate after excision of the tumor. Though these tumors are locally aggressive, Enzinger and Weiss did not report any malignant transformation or metastases.¹⁰

The lesion has a characteristic microscopic appearance. It is highly cellular and composed of spindle-shaped cells with plump, oval nuclei and indistinct cytoplasm separated by densely collagenous stroma. These fibroblastic cells extend with multiple processes into surrounding tissue, giving the lesion a poorly circumscribed appearance. In most areas, these cells predominantly are oriented in one direction giving a linear or palisaded arrangement. The tumor has centrally located foci of calcification and cartilage formation. Not infrequently, the fibrous growth is attached to tendons, aponeurosis, blood vessels, and nerves. Chondroid formation is seen in one third of cases. Osteoid formation is rare. Occasionally, giant cells are found in the vicinity of calcification.

The peculiar branching structures noted on microscopy in the present case and not described previously, are attributed to the destruction of elastic tissue. This destroyed and degenerated elastic tissue may be the site of, and may be responsible for, dystrophic calcification.

For symptomatic tumors, conservative surgical excision is the treatment of choice. Re-excision of a recurrent tumor is preferable to radical or mutilating surgical procedures.

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Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients, at a reduced dosage of 150 mg b.i.d. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H₂-receptor antagonists.

Precautions: General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy with nizatidine.

Drug Interactions—No interactions have been observed between Axid and theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 60 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose related increase in the density of enterochromatin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice; although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement

compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to

determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H₂-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD₅₀ values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

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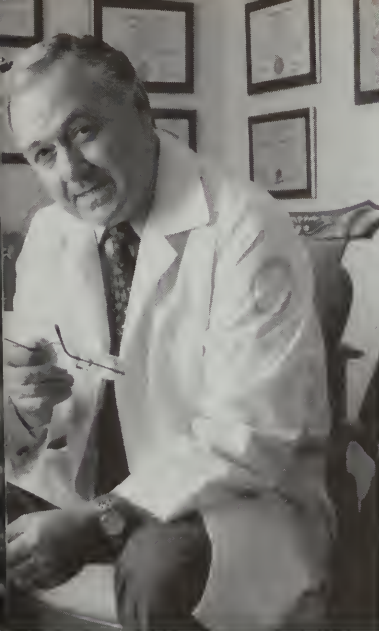
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CREATING THE ARCHIVES



LINDA COX, M.L.S., GERALDINE HUTNER, M.A., ROBIN KENNETT*

Will anyone remember the Medical Society of New Jersey? Afraid of what the answer might be, we decided we *would* be remembered. The fruits of such labors have become the archives of the Medical Society of New Jersey, a detailed registry of the history of the oldest medical society in the United States.

The importance of preserving and archiving one's past is not to be taken lightly. Our present depends on where we were and our future depends on where we are today. The lessons we learn from our predecessors are too valuable to be discarded or stored in cardboard boxes. It is in the intrinsic value of our ongoing history that we preserve the art and science of medicine, as are the insights we can pass on to our successors.

The continuing story of the first and oldest medical society of New Jersey was in danger of being lost. (The Medical Society of New Jersey was organized in 1766.) The loss of such an important part of New Jerseyana, Americana, and material medica prompted us to discover a way to save our history.

CREATING AN ARCHIVES

The archives of the Medical Society of New Jersey was created in 1988 with funds provided from a grant by the New Jersey Historical Commission. The purpose of the archives is to organize and preserve important New Jersey medical materials with historical and research value and to make these materials available to all interested persons.

The archives are housed in the editorial office of *NEW JERSEY MEDICINE*, the official publication of the Medical Society of New Jersey. Medical Society of New Jersey members are encouraged to deposit personal papers and documents with the archives. (Materials relating to the medical field and having historical and research value will be added to the collection, and revisions of the registry will be produced.) Inquiries regarding the use of the collection, duplications of any materials located therein, or donations of additional materials should be directed to the editorial office of *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648.

THE COLLECTION

The materials organized within the archives collection are from the files of the Medical Society of New Jersey along with material donated to the Society by former members and their families. The collection includes correspondence, scrapbooks, photographs, newspaper clippings, original pamphlets, original documents, rare and out-of-print books, and a small collection of medical instruments dating from the colonial period. Of particular interest are materials which were gathered from 1938 to 1941 for the 175th anniversary of the founding of the Medical Society of New Jersey; additional historical materials were gathered in 1965 to 1966 during preparations for the bicentennial celebration and for the publication of *The Healing Art*, a history of the Society. The earliest material in the collection includes two New Jersey legislative acts dating from the 18th century, and a page from a physician's account book dated 1794.

Papers and photographs are organized in acid-free folders in acid-free boxes—a total of 47 boxes, occupying 180 linear feet of shelf space. The collection of books along with the *Transactions* and *The Journal* occupy 325 linear feet of shelf space. The *Transactions* and *The Journal* also are available on microfilm. Oversized materials, framed documents, and the medical instruments are stored in a metal cabinet.

ARCHIVAL REGISTRY

The complete archival registry is housed at Society headquarters; all materials have been archived and catalogued. The following pages contain a condensed version of the archival registry; we have prepared this version to assist researchers in determining whether or not there is information in the collection which is relevant to their interests, and to allow readers a glance at the history of the oldest medical society in the United States. A detailed registry and alphabetical finding guide of the collection are available to the public in the archives room.

*Ms. Cox is director of the library, Blair Academy, Blairstown. Ms. Hutner is managing editor and Ms. Kennett is assistant to the managing editor, *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648.

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 Anderson, John F., MD
 Apgar, Francis A., MD
 Baillie, Matthew, MD
 Bainbridge, Absalom, MD
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 Barkhorn, Henry C., MD
 Bateman Family
 Beatty, John, MD
 Bernstein, Arthur, MD
 Burnet, William, MD
 Campbell, John, MD
 Conaway, Walt P., MD
 Craig, David S., MD
 Cummins, George W., MD
 Davidson, Henry A., MD
 Disbrow Family
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 Fort, George F., MD
 Godfrey, E., MD
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 Gulick, Selah, MD
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 Hartwell, H. Ameroy, MD
 Hawkes, Edward Z., MD
 Heineken, John F., MD
 Henderson, Thomas, MD
 Herrman, William G., MD
 Hunt Family
 Hunter, James, Jr., MD
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 Marcy Family
 Marsh Family
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 Moore, T.M., MD
 Morris, Watson B., MD
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 Mulford Family
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Stites, Hezekiah, MD
Stratton, James, MD
Taylor Family
Thomas, Floyd A., MD
Tyrrell, George W., MD

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 Canavan, David I., MD
 Cohen, Frederick B., MD
 Coye, Molly J., MD
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 Formica, Palma E., MD
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 MacDowall, J.D., MD
 Madara, John S., MD
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 Morrison, John B., MD
 Nafey, Herbert, MD
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 North, Harry R., MD
 Rigolosi, Robert, MD
 Ryan, William E., MD
 Saffron, Morris H., MD
 Schauer, Edward, MD
 Skilbred, Arne, MD
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 Folder 4: Medical Service Administration of New Jersey
 Folder 5: Medical Societies of the United States
 Folder 6: Medical Society of New Jersey Auxiliary, miscellaneous items: Constitution and By-Laws, 1929-1939; membership

certificate, 1930; roster of members, 1967-1988; membership cards; Shingle, 1985-1987

Folder 7: Medical Society of New Jersey Clinical Conferences, 1938-1947
 Folder 8: Medical Society of New Jersey Component Society Reporters, 1962-1964
 Folder 9: Medical Society of New Jersey Headquarters, photographs, 1940-1988
 Folder 10: Medical Society of New Jersey Pamphlets, 1970-1987
 Folder 11: Medical Society of New Jersey Poetry
 Folder 12: Medical Society of New Jersey Public Relations
 Folder 13: Medical Society of New Jersey Secretaries and Reporters Conference
 Folder 14: Medical Society of New Jersey Trustees, photographs of Board of Trustees, 1952-1987; minutes, 1931-1939
 Folder 15: Medical Surveys
 Folder 16: Milibank Fund
 Folder 17: National Physicians' Committee
 Folder 18: New Jersey Doctors' Almanac
 Folder 19: New Jersey Health and Welfare Conference
 Folder 20: Obituaries, members of the Medical Society of New Jersey
 Folder 21: Old-Time Country Doctor Shop
 Folder 22: Osteopathy
 Folder 23: Pharmacology
 Folder 24: Physicians' Incomes
 Folder 25: Rutgers University
 Folder 26: Society for the Relief of the Widows and Orphans of the Medical Men of New Jersey, 1934-1937
 Folder 27: Miscellaneous items: photographs; pamphlets; brochures

BOX: Miscellaneous Items

1: Page from physician's account book, 1785
 2: Recommendation for license for Elias J. Marsh, 1827
 3: Druggist bill, 1838
 4: Handwritten copy of license, 1865
 5: Scrapbook, Medical Society of New Jersey, 1893
 6: Photograph of members of Medical Society of New Jersey, 1893
 7: By-Laws, Rules, and Regulations of the District Medical Society for the County of Warren, 1825-1925
 8: Recording of the male chorus of Essex County Medical Society
 9: Document on the 175th anniversary of the Medical Society of New Jersey, 1941
 10: Document on the 200th anniversary of the Medical Society of New Jersey, 1966
 11: Certificate of commendation, 1967



Our cover photograph highlights the archives of the Medical Society of New Jersey. The medical books are a sampling from the rare book collection owned by MSNJ. The medical bag belonged to Jeems Brutus Spradley, MD (1896-1962), a hand-me-down from his family. The original minutes book (open) is from Warren County and dates from 1825. The black fountain pen was used by Governor Robert B. Meyner for official signing. The newspaper, the Bergen Evening Record, was a special edition highlighting the work of the Medical Society, from 1954.

BOX: Miscellaneous Books and Journals

- 1: American Medical Association, Transactions, 1860
- 2: Armstrong, John, Practical Illustrations of Typhus Fever, 1824
- 3: Cheselden, William, The Anatomy of the Human Body, 1806
- 4: Clark, James Henry, The Medical Men of New Jersey, 1867
- 5: Clark, James Henry, On The Elliptical Artificial Tympanum, and Chronic Discharges from the Ear, 1859
- 6: Conwell, Joseph A., Practical Medical Therapy, 1892
- 7: Cope, Zachary, The Early Diagnosis of the Acute Abdomen, 1927
- 8: Cowen, David L., Medicine and Health in New Jersey, 1964
- 9: Coxe, John Redman, The American Dispensatory, 1806
- 10: Cullen, William, The First Lines of the Practice of Physic, 1784
- 11: Denman, Thomas, An Introduction to the Practice of Midwifery, 1807
- 12: The Dispensatory of the United States of America, 1836
- 13: Emerson, L. Eugene, Physician and Patient: Personal Care, 1929
- 14: Faraday, Michael, Chemical Manipulation, 1831
- 15: Foster, Frank P., Medical Dictionary, 1890
- 16: Fyfe, Andrew, A Compendious System of Anatomy, 1805
- 17: Goldthwait, Joel E., Body Mechanics, 1934
- 18: The Harvey Lectures, 1935-1949
- 19: Hunt, Ezra Mundy, The Medical Profession, Its Position and Its Claims as a Science, a Business, and an Art, 1865
- 20: Leake, John, Medical Instructions Towards the Prevention and Cure of Chronic Diseases Peculiar to Women, 1787
- 21: Lichtwitz, Leopold, Pathology and Therapy of Rheumatic Fever, 1944
- 22: The Medical Recorder, 1824-1828
- 23: Medical Society of New Jersey, Transactions, 1766-1903
- 24: The New Jersey Medical Reporter and Transactions of the New Jersey Medical Society, 1849-1855
- 25: New Jersey Medicine, 1985-1988
- 26: Journal of the Medical Society of New Jersey, 1904-1985
- 27: Philip, Alexander P., A Treatise on Febrile Disease, 1809
- 28: Watson, William P., An Address on Cholera Infantum, 1885
- 29: Watson, William P., The Therapeutics of High Temperature in Young Children, 1885
- 30: Watson, William P., The Value of Creosote in 50 Cases of Disease of the Air Passages, 1889



New Jersey is well known for its medical families. The story of the Marsh family begins with Elias Joseph Marsh, MD (top). Born in 1803, Dr. Marsh became the 57th president of the Medical Society of New Jersey in 1850—the year of his death. His portrait has been preserved, as is a certificate dated July 1824 licensing Dr. Marsh to practice physic and surgery throughout the state of New Jersey (left). His son, Dr. Elias J. Marsh (facing page, top) was born in 1835 and became president of the State Society in 1891. He died in 1908. The third generation continued the tradition with Elias Joseph Marsh, MD (facing page, bottom right). Born in 1875, Dr. Elias Joseph Marsh was an active member of the state society and became its 150th president in 1942. He authored a pamphlet, "An Outline History of the Medical Society of New Jersey to 1903," in 1942 (facing page, bottom left) and presented the paper to the New Jersey Historical Society in January of that year. Dr. Marsh died in 1942.

This will Certify, that we, Charles Smith and
Jacob Dunham and John J. ...

...; Censors of the District Medical Society
for the County of Middlesex, appointed by the Medical
Society of New Jersey, have this day carefully and impartial-
ly examined *Elias Joseph Marsh*
of Perth Amboy, County of Middlesex,
and State of New Jersey; and being well satisfied with
his attainments in the various branches of Medical and Surgical Science,
and of his moral character; do hereby recommend him to the President
of the Medical Society of New Jersey, as a proper person, to re-
ceive a licence to practice **PHYSIC** and **SURGERY** throughout the
State of New Jersey.

In testimony whereof, we have hereunto subscribed our names and
affixed our seals, at New Brunswick this 14th
day of July, Anno Domini 1824.

Chas. Smith
Jacob Dunham
John J. ...



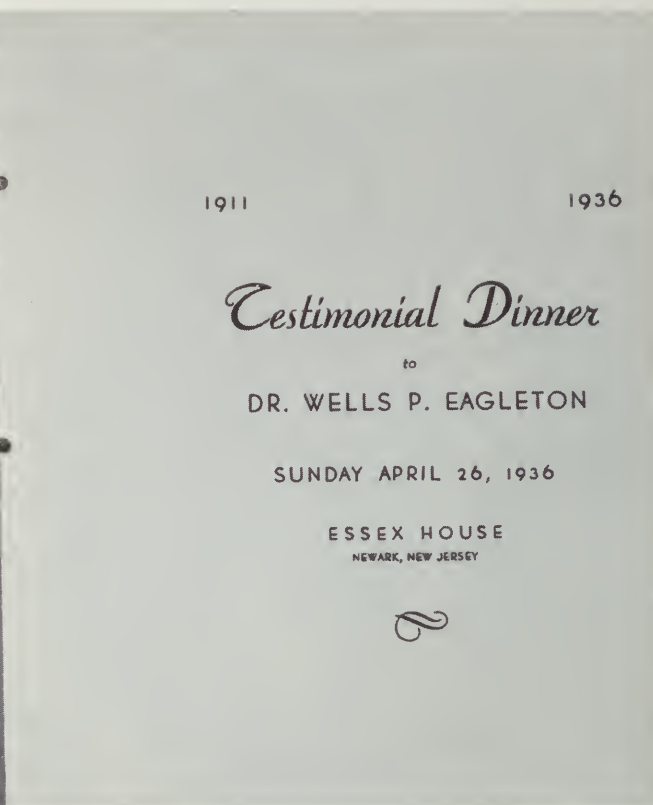
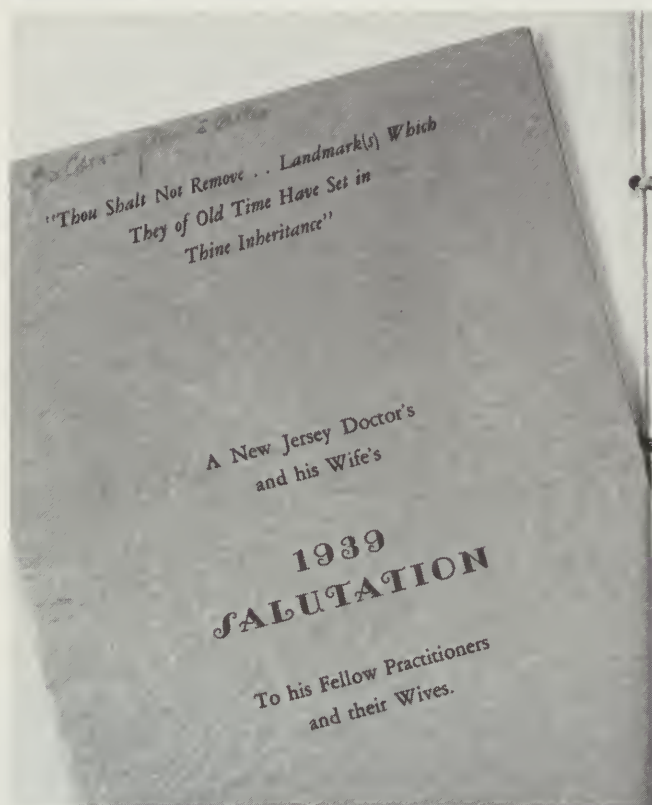
*An Outline History of the
Medical Society of New
Jersey to 1903*

BY ELIAS J. MARSH, M. D.
PATERSON

REPRINTED FROM
PROCEEDINGS OF THE NEW JERSEY HISTORICAL SOCIETY
JANUARY, 1942



E. J. Marsh



Wells P. Eagleton, MD (right), was the president of the Medical Society of New Jersey in 1923. On April 26, 1936, Dr. Eagleton (1865-1946) was honored at a testimonial dinner at the Essex House in Newark; the six-page program listed the evening's events and a photograph of Dr. Eagleton (top right). Two years later, on November 16, 1938, Dr. Eagleton presented an address to the Union County Medical Society entitled, "A New Jersey Doctor's and His Wife's 1939 Salutation to his Fellow Practitioners and Their Wives." The speech was published in January 1939 (top left) and distributed to all members of the Medical Society of New Jersey.

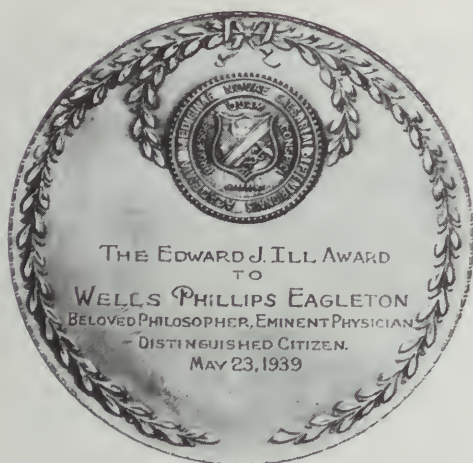


Yours very truly,
Wells P. Eagleton
W.P.E.S.

Edward J. Ill, MD (right), served as the 114th president of the Medical Society of New Jersey in 1907. He dedicated himself to his profession and to organized medicine. To honor his achievements, the Academy of Medicine of New Jersey, in 1939—on his 85th birthday—established the Edward J. Ill Award to be presented to a New Jersey physician for his dedication and service to the medical profession. Dr. Eagleton (facing page) was the first recipient of this medal (bottom).



Edward J. Ill





Needing a new headquarters building, the Medical Society of New Jersey purchased the Kuser property (top) in 1944 for \$44,000. The house at 315 West State Street was constructed in 1905 for the well-known Trenton, New Jersey family who lived in the house until 1943. A Committee was appointed by the MSNJ Board of Trustees to oversee the purchase of the property (left to right): Drs. Frank G. Scammell, Andrew F. McBride, Joseph F. Londrigan, president, and Harry R. North.



The Journal of The Medical Society of New Jersey.

Published on
the First Day of Every Month.



Under the Direction
of the Committee on Publication.

COMMITTEE ON PUBLICATION:
WILLIAM J. CHANDLER, M.D. DAVID C. ENGLISH, M.D. HENRY W. ELMER, M.D.
RICHARD COLE NEWTON, M.D., Editor.

Vol. I. No. 1. Newark, N. J., September, 1904. Subscriptions, \$2.00 Per Year. Single Copies, 25 Cents.

Address all communications relating to the business of the paper, advertisements and subscriptions to
WILLIAM J. CHANDLER, M.D., 105 South Orange Ave., South Orange, N.J.
Address all papers on medical subjects, all news items, and all books for review to RICHARD C. NEWTON, M.D.,
105 South Orange Ave., South Orange, N.J.
The Journal will be glad to print original papers from any source, preferably from members of the State
Society, provided that they will be of sufficient merit and shall be contributed to this paper exclusively.
As to news communications will not be published, but the name of the author of a communication will
be kept secret if the editor is requested to do so.
The Medical Society of New Jersey does not hold itself responsible for the sentiments expressed by the authors
of papers.
It will be satisfactory to all concerned if authors will have their contributions typewritten before submitting
them for publication. The expense is small—the author's gain is great to the editor and printer. We
do not promise to return unused manuscripts.

ANNOUNCEMENT BY THE COMMITTEE ON PUBLICATION.

The Medical Society of New Jersey at its
annual meeting favorably considered
the idea of journalizing its transactions, but
left its final decision with its Board of Trustees,
giving them the power to do so this
year, if in their judgment it was deemed
wise. The board, at a meeting held July 6,
1904, unanimously decided in favor of issuing
a monthly journal to be called "The
Journal of the Medical Society of New Jersey,"
and the management and control of
the same was placed in the hands of the
Publication Committee, according to the
provisions of the constitution and by-laws of
the Society.

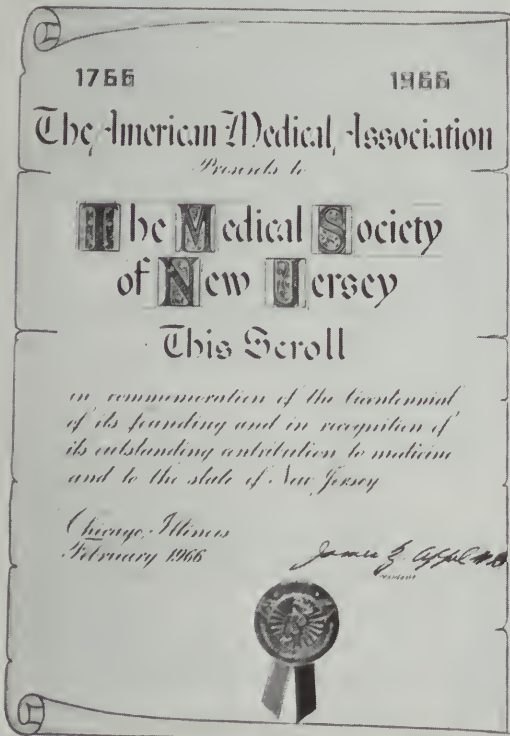
The committee, in accepting this great responsibility,
are pleased to inform and congratulate the members of the Society and the
profession at large, that the Board of Trustees

at the same meeting appointed Dr.
Richard C. Newton, of Montclair, editor of
the JOURNAL. The Publication Committee
bespeak for him the active co-operation of
the members of the State Society and especially
of its officers and committees and the
secretaries of our County Societies, as it
is his and our desire to make the JOURNAL
not merely a substitute for the annual volume
of transactions of the Society, but also an
up-to-date, bright, scientific medical journal,
that shall prove helpful to the members
of the profession in their practical work and
scientific advancement.

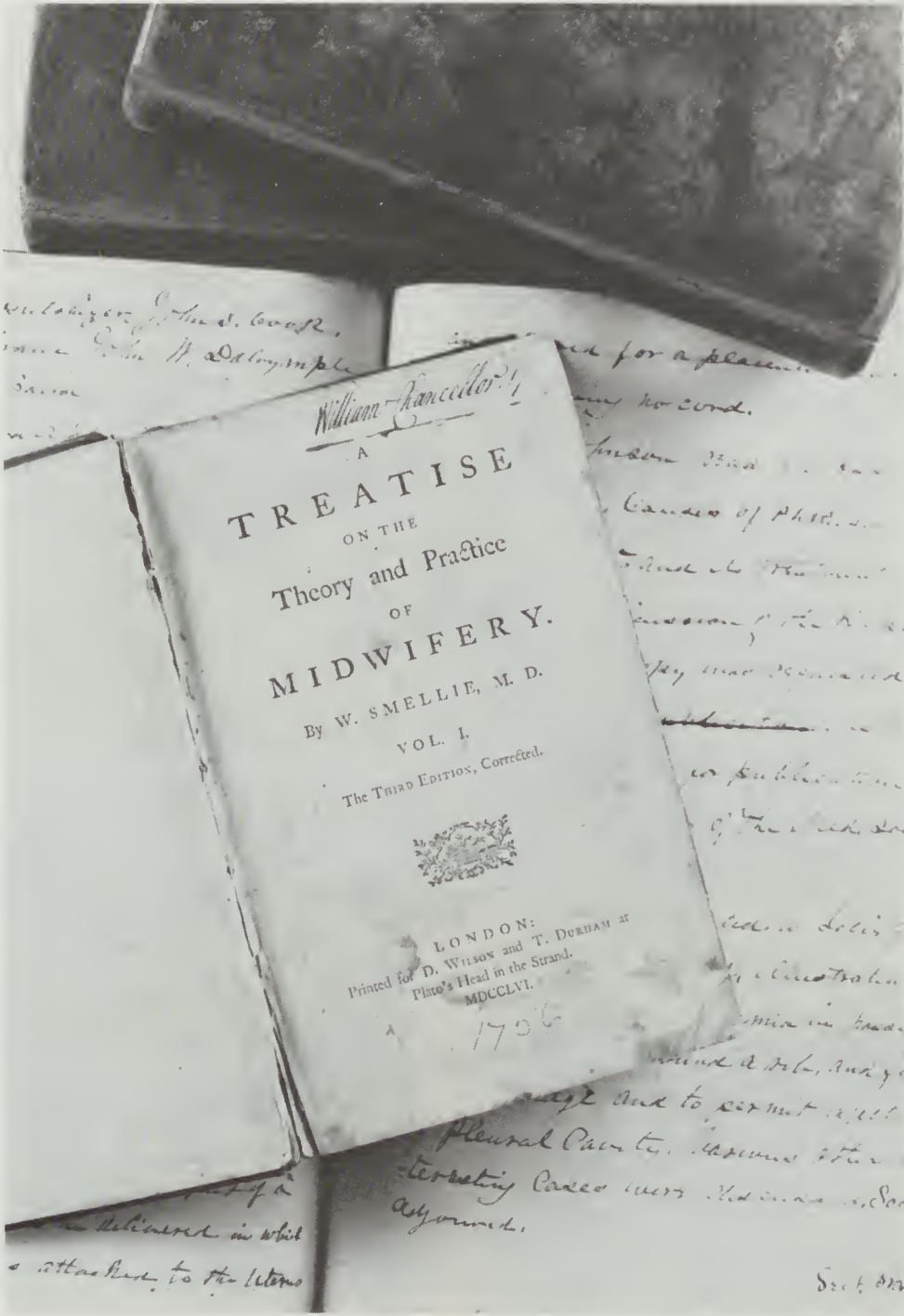
The committee also commends this JOURNAL
to the favorable consideration of advertisers.
Realizing that our readers compose
almost the entire body of regular practitioners
between the two great centres of medical

The Journal of the Medical Society of New Jersey was first published in September 1904 (top) under the direction of Editor David C. English, MD. In 1934, Frank Overton, MD (bottom right), became the editor; for the next seven and one-half years, Dr. Overton devoted himself to the journal and to creating a written history of the Medical Society of New Jersey. The photograph of Dr. Overton was taken in 1940 at the Society's Annual Meeting where he led a discussion on the value of membership in the state society. In 1941, Henry A. Davidson assumed the editorship of the state medical journal and was responsible for the cover artwork during the Society's bicentennial in 1965; the four-color cover featured the plaque from the American Medical Association honoring the 200th anniversary of the Medical Society of New Jersey (bottom left).

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY



Frank Overton, M. D.,
Editor.



The Medical Society of New Jersey owns over 40 rare medical books including the two books shown here: *A Treatise on the Theory and Practice of Midwifery* by William Smellie and *The Anatomy of the Human Body* by William Cheselden. Smellie's book, dated 1756, was owned by Dr. Lawrence Van Der Veer. Cheselden's volume was published in 1806 and was the second American edition.

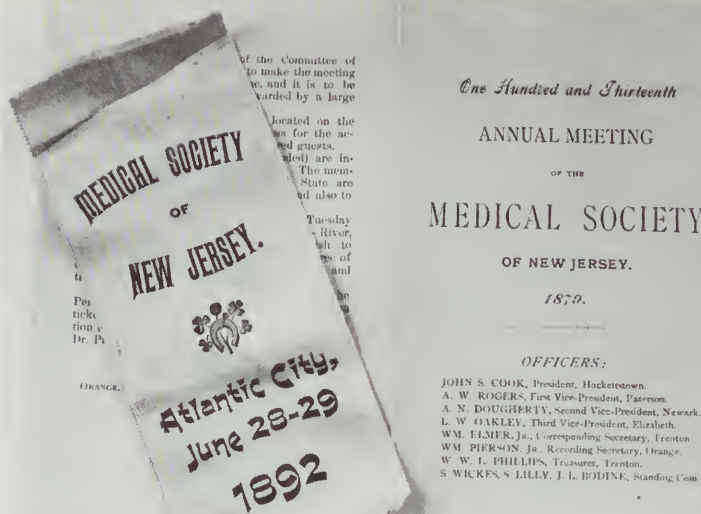
Two of the oldest items in the Archives of the Medical Society of New Jersey are shown on this page. A druggist's bill (top) dated July 6, 1838, contains a listing of all prescribed drugs for the Suydam family; the total accounting for three years, 1835-1838, came to \$179.50. A physician's ledger (bottom) dated 1785 belonged to Robert R. Henry, M.D., for his patient John Wortman, Esquire. The ledger was kept from 1785 to 1794 and was for all family members; note that expenses were listed in pounds, shillings, and pence.

Charles Suydam
Dr. R. R. Henry

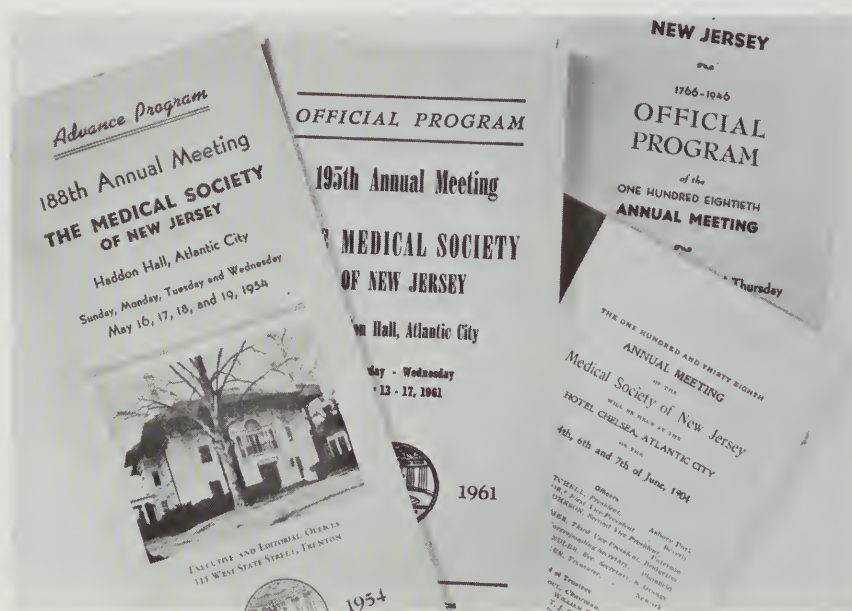
June 1st 1835 to July 6th 1838	
No. 1. Blue pills 32.	1.50
Alkaline powder super.	
Carb. Soda 10 powder	1.75
No. 2. Dover powder 10	2.25
No. 3. Tefugeant powder 10	1.50
Calomel 10	3.25
Magnesia best.	1.25
No. 4. Antimonial powder 10	0.50
Antiseptic white best	1.50
No. 5. Dover powder 10	2.50
Blending	2.50
No. 6. Blue pills 10	1.25
No. 7. Tefugeant powder 10	1.50

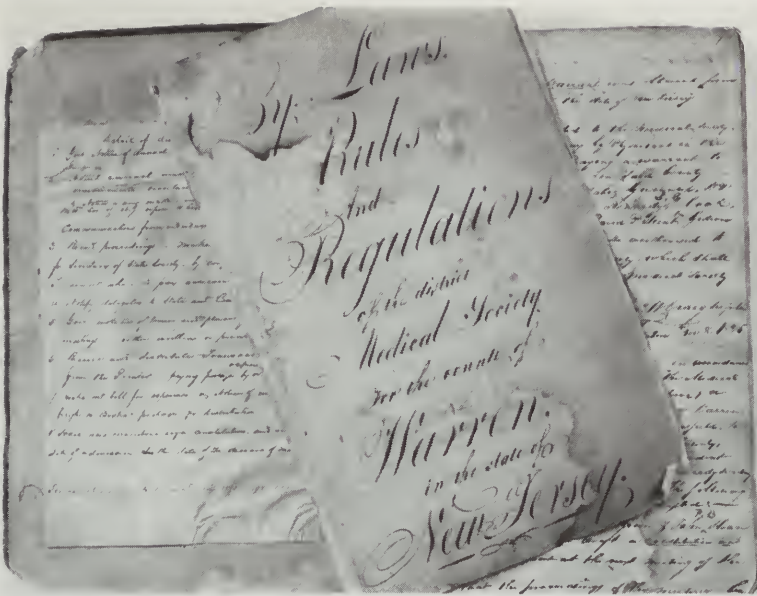
John Wortman Esq Dr. R. R. Henry

Date	Description	Pounds	Shillings	Pence
1785. 3 Aug.	advised	1	3	0
5 Sept	Delating her breast	1	2	0
9 Dec	advised	1	3	0
27 Aug	advised	1	3	0
	Manna at present time	1	2	0
	Pill Pacific	1	2	0
27	advised	1	2	0
	Pill Alactic	1	3	0
19 Sept	Pill Pacific	1	3	0
	advised	1	3	0
	advised	1	3	0
5	advised	1	3	0
6	advised	1	3	0
1786 4 Sept	advised	1	3	0
14	advised	1	3	0



The Medical Society of New Jersey is the oldest medical society in the United States. In the 1800s, Atlantic City was the host town for the MSNJ Annual Meetings. At the 1892 meeting, beige ribbons were attached to physician name badges (top). For the 113th Annual Meeting, programs were printed listing names of officers and events for the two-day meeting (top). With succeeding years, the official programs grew bigger and bigger, detailing events for the Annual Meetings and disseminating information about the Society (bottom). Programs from 1904, 1946, 1954, and 1961 are outstanding examples of work published by the Society.

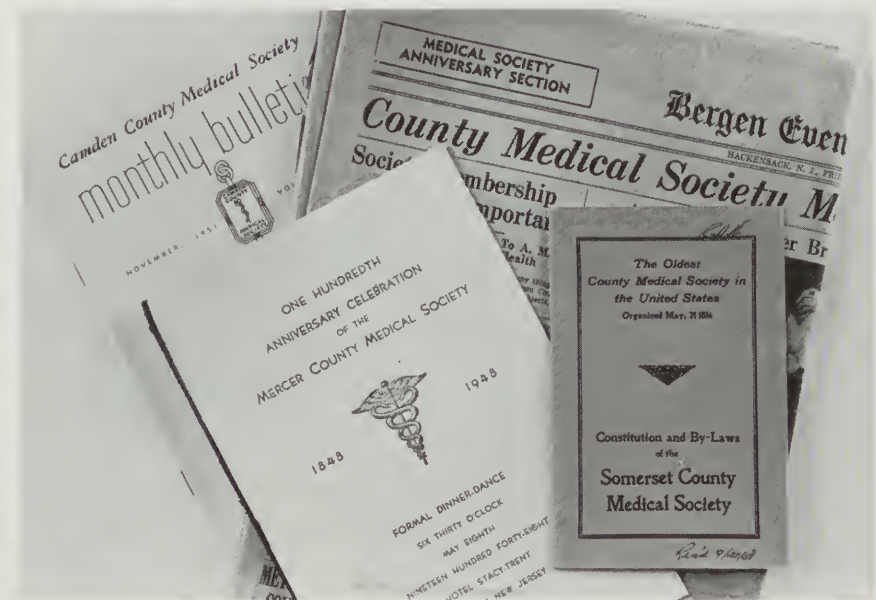




County medical societies have played a major role in the growth and development of the Medical Society of New Jersey. The Archives of the Medical Society houses the original minutes book for the formation of the Warren County Medical Society entitled, "Bylaws, Rules and Regulations of the district Medical Society for the county of Warren," dated 1826 (left).



In 1937, members of the Hunterdon County Medical Society (middle) were photographed to encourage others to join. And, county societies publish a variety of informational material (right) for members, including; "Constitution and By-Laws of the Somerset County Society," 1958; "One Hundredth Anniversary Celebration of the Mercer County Medical Society," 1948; "Camden County Monthly Bulletin," 1951; and, a special anniversary newspaper article on the Bergen County Medical Society.





William Carlos Williams, MD, was a New Jersey pediatrician and a world-renowned poet. In 1973, the Medical Society of New Jersey devoted a special issue of its journal to honor Dr. Williams. On this 100th anniversary of his birth, Editor Arthur Krosnick, MD, and Guest Editor Avrum Katcher, MD, amassed a selection of poetry, prose, and artwork and solicited new articles on the private and public life of Dr. Williams. A four-color commissioned portrait of Dr. Williams by New Jersey artist Judi Neimann (left) was the cover of the journal in September 1973. A original signature of Dr. Williams from a hospital medical record, dated 1910, appears below his picture.



John Bennett Morrison, MD (left), was secretary of the Medical Society of New Jersey from 1923 to 1937. This photograph of Dr. Morrison was taken in 1937 and is signed.

Underwritten by the Medical Society of New Jersey

Secretary of the Medical Society of New Jersey from 1923 to 1937 incl.

John B. Morrison.

During his tenure as secretary, Dr. Morrison wrote a public relations pamphlet for the society, "Membership in the Medical Society of New Jersey, Is It Worth the Price?" Published in 1930 (right), and distributed to all members, the address was read before the Hudson County Medical Society.

MEMBERSHIP
in the
Medical Society
of New Jersey

**IS IT WORTH
THE PRICE?**

John Bennett Morrison, M.D.
Newark, N. J.

Woman's Auxiliary of the New Jersey Medical Society



The Auxiliary of the Medical Society of New Jersey was established in 1927 and its first president was Mrs. A. Haines Lippincott (left). The Auxiliary is proud of its publication, *The Shingle*, once called *New Jersey Newsletter*. A collection envelope from 1936 (bottom) created by the Essex County Medical Society to raise funds stated, "16 pennies make a foot; 5280 feet make a mile. That will be \$844.80." And, members in the county who paid their dues, received a membership card (bottom). Membership rosters have become standard for the Auxiliary; on many of the back covers the following message is printed: "I pledge my loyalty and devotion to the Auxiliary of the Medical Society of New Jersey and to the American Medical Association. I will support their activities, protect their reputations, and ever sustain their high ideals."

THE NEW JERSEY NEWSLETTER

THE NEWSLETTER
OF THE
WOMAN'S AUXILIARY
OF THE
NEW JERSEY MEDICAL SOCIETY
FOR MAY 1936
EDITED BY
MRS. A. H. LIPPINCOTT
TREASURER
MRS. J. H. LIPPINCOTT
SECRETARY
MRS. J. H. LIPPINCOTT
MEMBERSHIP
MRS. J. H. LIPPINCOTT
OF EACH MONTH

CONVENTION LIGHTS

When they came to the convention, they were met by Mrs. A. H. Lippincott, president of the auxiliary, and Mrs. J. H. Lippincott, treasurer. They were then taken to the hotel where they stayed for the night. The convention was held at the Hotel New Jersey, and was a great success. The auxiliary was very active in the convention, and did a great deal of work. The convention was held at the Hotel New Jersey, and was a great success. The auxiliary was very active in the convention, and did a great deal of work.



Left to right: Mrs. A. H. Lippincott, president; Mrs. J. H. Lippincott, treasurer; Mrs. J. H. Lippincott, secretary; Mrs. J. H. Lippincott, membership; Mrs. J. H. Lippincott, of each month.



Mrs. A. H. Lippincott, president.



Mrs. J. H. Lippincott, treasurer.

chairman of A.M.A.'s Council on Legislative Action. The convention program began Monday morning, June 8, with work shop conferences for all interested members. The afternoon tea and fashion show featured Mrs. Underwood and Mrs. Frank Gastmann, President Elect. The last model gave out a basket of gifts, all her clothes were very having suits and accessories. The lucky model holders in the audience wearing an evening blouse to a grand presentation of beautiful fashions and high heels.

The luncheon of Tuesday, in honor of the past presidents, featured Mrs.

Dr. Gunnar Gundersen of La Crosse, Wisconsin, immediate past president of the American Medical Association spoke on international medicine as a force for world peace at the luncheon on Wednesday in honor of Mrs. Underwood and Mrs. Gastmann. Guests of honor were the officers and members of the Board of Trustees of the A.M.A. and wives of officers and trustees.

Auxiliary members joined their husbands and friends on Tuesday evening to attend the inauguration of Dr. Louis M. Orr of Orlando, Florida as the 113th president of the American Medical Association.

In his inaugural address Dr. Orr

On Closing Our Ranks

Apparently for the first time in the history of the American Medical Association...

**16 PENNIES
MAKE A FOOT;
5280 FEET
MAKE A MILE.
THAT WILL BE
\$844.80**

**Woman's Auxiliary to the
Essex County Medical Society**
wish to raise a mile of pennies. If you don't send your foot we may miss our mile. So will you please put 16 cents in this envelope and send to our Treasurer.
MRS. R. A. WALLHAUSER
91 Center Ave. Maplewood, N. J.

the citizen to the status of the government ultimately the servant of the State...
Woman's Auxiliary to the Essex County Medical Society
This Certificate that is a member in good standing during the year 1936
MEMBERSHIP CARD
NOT TRANSFERABLE
TO BE SHOWN AT EACH MEETING
Secretary
Treasurer
President
Vice President
Members

the citizen to the status of the government ultimately the servant of the State...
the citizen to the status of the government ultimately the servant of the State...
the citizen to the status of the government ultimately the servant of the State...

**I pledge my loyalty and devotion to the
Auxiliary to the Medical Society of New Jersey
and to the American Medical Association.**
**I will support their activities, protect their
reputations, and ever sustain their high ideals.**

CAMDEN COUNTY
The first meeting will be held on...
The first meeting will be held on...
The first meeting will be held on...



To Uncle Jack from
 Julia Allison Probst

In 1890, the Englewood Hospital was established to serve the local community. The picture of the hospital as it was in 1905 is preserved on this postcard sent by Julia Allison Probst to her Uncle Jack Allison in Germany. Postmarked Bonn, the card needed one penny for domestic postage and two pennies for foreign postage.



OVER 3500 PATIENTS AND THEIR PHYSICIANS HAVE USED OUR LITHOTRIPTER SERVICE.

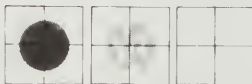
In a field where experience is often measured in days or months, the Mid-Atlantic Kidney Stone Center stands apart. With nearly three years of expertise as a lithotripsy service, we have treated more than 3500 kidney stone patients resulting in a high degree of confidence by referring physicians in New Jersey, Eastern Pennsylvania, metropolitan New York, and Delaware.

Our concern for the patient's well-being is central to our con-

cept of good patient care. Our professional staff prepares the patients for every aspect of treatment with warmth and understanding. We spend a great deal of time with patients to reassure them and explain the procedure. And patients appreciate the personalized care of the Mid-Atlantic Kidney Stone Center.

Our relationship with referring physicians ensures quality care by providing timely communica-

tions during your patient's treatment. In addition, we are available 24 hours a day for pre- and post-treatment consultation. We believe this cooperation between the referring urologist and the staff at Mid-Atlantic is essential to effective treatment and recovery. To find out more about our service, or to obtain staff privileges at the Mid-Atlantic Kidney Stone Center, call (609) 983-7337 or (800) 53-LITHO.



THE MID-ATLANTIC KIDNEY STONE CENTER

A LITHOTRIPTER SERVICE
One Brick Road, Suite 103
Marlton, NJ 08053

Managed by MEDIQ Healthcare Resources, Inc.

***UMDNJ Notes; Physicians
Seeking Location in
New Jersey***

SOM target AIDS, cancer, heart disease, diabetes, disorders of aging, and other unsolved medical problems.

Funds for the building were provided by state legislation aimed at strengthening medical education in southern New Jersey and enhancing the region's health care and biomedical research environment.

At present, the 112 first- and second-year students at UMDNJ-SOM receive their basic science education at UMDNJ-Piscataway Campus along with students at UMDNJ-Robert Wood Johnson Medical School. For their third and fourth years, the SOM students go to southern New Jersey for their clinical course of study, which is divided between UMDNJ's Education and Research Building in Camden, and the clinical center in Stratford.

A new multidisciplinary team of specialists has been assembled at our Newark-based New Jersey Medical School to treat children born with cleft lips and palates. The team, which provides the service at a bimonthly clinic at University Hospital, combines the talents of plastic surgeons, dentists, genetic counselors, and speech therapists.

Under the direction of Dr. Paul LoVerme, a plastic surgeon and UMDNJ alumnus, the service sees patients as early as infancy, counseling parents before they leave the hospital with the newborn.

For the very young, appliances are used in the palate area to help realign the bone before surgery to achieve a better result. Dr. LoVerme said that when a cleft is present, there also is muscle deficiency that affects the basic acts of breathing, eating, talking, and smiling.

Surgical repair usually is done in two stages, first the lip and then the palate. Dental specialists can help realign teeth or supply a prosthesis, or artificial part, as a replacement for areas not brought together.

Speech therapists help teach speech patterns that can overcome physical limitations. Genetic counseling is important because one-third of those with the birth defect have a family history. In fact, Dr. LoVerme said, the numbers are increasing because the cosmetic and functional repairs are so good that more people with cleft lip and palate marry and have children.

A physician-scientist at our School of Osteopathic Medicine has shown a group of simple carbohydrates, called sulfated monosaccharides, to be powerful agents against AIDS virus. In a paper presented at the International AIDS conference in Stockholm, Dr. Omar Bagasra, associate professor of immunology and microbiology, reported that half of the 18 compounds tested in his laboratory completely inhibited the spread of HIV. Two of the most effective substances he tested were glucosamine disulfate and inositol hexasulfate, which are both single-compound sugars.

Dr. Bagasra noted that the compounds he tested are plentiful so those that eventually proved safe and effective in humans could be available for pennies per dose. Currently, treatment of AIDS with AZT can cost up to \$200 a week.

Free dental services for the elderly are being expanded by UMDNJ's Newark-based New Jersey Dental School. Supported by a grant from the New Jersey Department of Community Affairs, the School is initiating a geriatric internship program that will allow seven dental students to provide 200 hours of dental services to the elderly.

The students will travel to selected senior citizen complexes, nutritional centers, and nursing homes in northern New Jersey, as well as to three established centers which already provide geriatric dental care. Treatment sites have been identified in Essex County and the school's geriatric division is seeking centers elsewhere that also could benefit from this program.

The three existing locations for geriatric dental care are the Institute for Alzheimer's Disease and Related Disorders; the UMDNJ-Community Mental Health Center at Piscataway; the Essex County Geriatric Center; and the West Orange Municipal Dental Center. The dental school has offered services to these centers periodically in the past, but now will be able to do so on a more regular basis.

The students will present lectures on restorative and preventive dental techniques and perform oral examinations. Those senior citizens with the need for treatment will be referred to the school's Newark campus or one of the three existing satellite centers.

UMDNJ Notes

**Stanley S. Bergen, Jr., M.D.
President**

UMDNJ's School of Osteopathic Medicine (SOM) has begun phase two of a five-year plan to unify its three campuses, as ground was broken for a research and education building in Stratford.

The \$9.45 million three-story building is the second of four facilities which will comprise a new four-year campus for the osteopathic medical school. An ambulatory health care center, the school's clinical center, was completed last year. Academic and administration buildings are scheduled to finish the project in 1990.

The building will house laboratories, classrooms, and a vivarium, as well as facilities for electron microscopy, tissue and cell culture, and other research support areas. Ongoing research programs at UMDNJ-

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY—Grant H. Greeley, M.D., 6305 Snow Heights Ct., El Paso, TX 79912. SUNY Downstate 1979. Also, internal medicine. Board certified. Also, board certified (IM). Partnership or multispecialty group within commuting distance of New York City. Available May 1989.

CARDIOLOGY—Donald G. Rubenstein, M.D., 1037 3rd St., #303, Santa Monica, CA 90403. Louisiana 1980. Board eligible. Group or partnership. Available.

DERMATOLOGY—Cheryl S. Citron, M.D., 885 Sussex Rd., San Marino, CA 91108. Miami 1984. Board eligible. Group, partnership, solo. Available.

FAMILY MEDICINE—John Travers, M.D., 14225 Kendra Way, Poway, CA 92064. UMDNJ 1982. Group or HMO. Available.

GASTROENTEROLOGY—Howard P. Fritz, M.D., 14 Baldwin Ct., Newington, CT 06111. St. Louis 1984. Also, internal medicine. Board eligible. Board certified (IM). Available July 1989.

INTERNAL MEDICINE—Howard P. Fritz, M.D., 14 Baldwin Ct., Newington, CT 06111. St. Louis 1984. Also, gastroenterology. Board certified. Available July 1989.

Grant H. Greeley, M.D., 6305 Snow Heights Ct., El Paso, TX 79912. SUNY Downstate 1979. Also, allergy. Board certified (ALLERGY). Partnership or multispecialty group within commuting distance of New York City. Available May 1989.

Lalitha B. Iyer, M.D., 84 Hempstead Dr., Somerset, NJ 08873. Madras (India) 1980. Board eligible. Group, partnership, emergency room. Available.

ORTHOPEDICS—Paul Bizzigotti, M.D., 230 E. 12 St., #7A, New York, NY 10003. NYU 1981. Board eligible. Group or partnership. Available.

Joseph M. Grant, M.D., Naval Hospital, Box 8, FPO San Francisco, CA. UMDNJ 1980. Board eligible. Group or partnership. Available July 1989.

PEDIATRICS—Linda York-Chance, M.D., 435 East 70th St., New York, NY 10021. Connecticut 1985. Board eligible. Clinic or emergency room. Available.

Iraj Modarai, M.D., 40 Cherry Hill, Springfield, VT 05156. Tabriz (Iran) 1956; Polyclinic 1963. Board certified. Clinic, emergency, salary. Available.

PHYSICAL MEDICINE AND REHABILITATION—Robert B. Thorne, M.D., 1219 East Northern Pkwy., Baltimore, MD 21239. Rutgers 1980. Board certified. Available.

RADIOLOGY—Joseph M. Ullman, M.D., 148 Chestnut Crossing Dr., Apt. 1, Newark, DE 19713. George Washington 1984. Board eligible. Group, partnership, community hospital, outpatient imaging center. Available July 1989.

SURGERY—Andrea Resciniti, M.D., 4 Duncannon Ave., Apt. 9, Worcester, MA 01604. Hahnemann 1983. Board eligible. HMO, multispecialty, group, single specialty group. Available.

UROLOGY—Joseph G. Colonna, M.D., 503 Captain Dement Dr., Waldorf, MD 20601. Guadalajara 1977. Board certified. Group, partnership, solo. Available.

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Hahnemann University

Department of Medicine

GRAND ROUNDS

September - December 1988
8:30 AM - 9:30 AM

SEPTEMBER, 1988

September 7, 1988
AIDS AND AIDS RELATED INFECTIONS
 Martin S. Hirsch, M.D.
 Professor of Medicine, Infectious
 Disease Unit, Harvard Medical School
 Massachusetts General Hospital
 Boston, MA

Louis M. Van de Beek, M.D.
 Director, AIDS Activities Coordinating
 Office, Philadelphia Health Dept.,
 Philadelphia, PA

September 14, 1988
DEPARTMENT OF MEDICINE
FACULTY RESEARCH PRESENTATIONS
 Faculty, Department of Medicine
 Hahnemann University
 Philadelphia, PA

September 21, 1988
NO GRAND ROUNDS — YOM KIPPUR

September 28, 1988
OSTEOMYELITIS
 Layne O. Gentry, M.D.
 Chief, Infectious Disease Division
 St. Lukes Hospital; Houston, TX

OCTOBER, 1988

October 5, 1988
OSTEOPOROSIS
 Louis V. Avioli, M.D.
 Professor of Medicine, Division of Bone
 and Mineral Diseases, Washington Univ.
 at Jewish Hospital; Dir. of Endocri-
 nology; Jewish Hospital; St. Louis, MO

October 12, 1988
PULMONARY VASCULITIS
 Gary W. Hunninghake, M.D.
 Director, Pulmonary Diseases,
 Dept. of Medicine, Univ. of Iowa;
 Iowa City, IA

October 19, 1988
THROMBOLYSIS AND P.T.C.A. IN
ACUTE MYOCARDIAL INFARCTION
 David O. Williams, M.D.
 Professor of Medicine, Brown Univ.;
 Director, Cardiac Catheterization,
 Rhode Island Hospital; Providence, RI

October 26, 1988
COAGULATION DISORDERS
 Isadore Brodsky, M.D.
 Professor and Chairman, Dept. of
 Neoplastic Diseases, Hahnemann Univ.
 Philadelphia, PA

James F. Conroy, D.O.
 Professor of Medicine, Dept. of
 Neoplastic Diseases, Hahnemann Univ.
 Philadelphia, PA

Gerald Soslaw, Ph.D.
 Assoc. Professor, Dept. of Biochemistry
 Hahnemann Univ.; Philadelphia, PA

NOVEMBER, 1988

November 2, 1988
VASODILATORS IN MEDICINE:
CALCIUM CHANNEL BLOCKERS vs.
ACE INHIBITORS
 Martin B. Leon, M.D.
 Sr. Investigator and Co-Director,
 Cardiac Catheterization Laboratory
 National Institutes of Health
 Bethesda, MD

Barry F. Uretsky, M.D.
 Assoc. Professor of Medicine, Division
 of Cardiology, Univ. of Pittsburgh
 Pittsburgh, PA

November 9, 1988
PHARMACOKINETICS OF CARDIO-
ACTIVE DRUGS
 Roger W. Jelliffe, M.D.
 Professor of Medicine and Director,
 Applied Pharmacokinetics, Univ. of
 Southern California; Los Angeles, CA

November 16, 1988
DIABETIC NEPHROPATHY AND
HYPERTENSION
 Leopoldo Raij, M.D.
 Professor of Medicine and Director,
 Div. of Nephrology and Hypertension
 Veterans Administration Hospital
 Minneapolis, MN

November 23, 1988
ACUTE LEUKEMIA
 Robert L. Capizzi, M.D.
 Section Chief, Hematology and
 Oncology, Bowman-Gray Medical
 School; Winston-Salem, NC

November 30, 1988
MANAGEMENT OF HYPERLIPIDEMIA
 Basil M. Rifkin, M.D.
 Chief, Lipid Metabolism Atherogenesis
 Branch; Div. of Heart and Vascular
 Disease; National Heart, Lung & Blood
 Institute; Bethesda, MD

DECEMBER, 1988

December 7, 1988
NEW CONCEPTS IN ISCHEMIC HEART
DISEASE
 James F. Spann, M.D.
 Professor of Medicine and Chief of
 Cardiology; Univ. of South Carolina
 School of Medicine; Charleston, SC

December 14, 1988
PITUITARY TUMORS
 Lawrence G. Gray, M.D.
 Clinical Asst. Professor, Dept. of
 Neurology; Chief, Neuro-Eye Service
 Philadelphia Eye Institute
 Philadelphia, PA

Eric D. Hoover, M.D.
 Asst. Professor, Section of
 Neuroradiology; Dept. of Diagnostic
 Radiology; Hahnemann University
 Philadelphia, PA

Leslie I. Rose, M.D.
 Professor of Medicine and Director,
 Division of Endocrinology-Metabolism
 Hahnemann Univ.; Philadelphia, PA

Jeffrey S. Yablon, M.D.
 Sr. Instructor, Dept. of Neurosurgery
 Hahnemann Univ., Philadelphia, PA

December 21, 1988
CPC
 Howard A. Miller, M.D.
 Professor of Medicine
 Hahnemann Univ.; Philadelphia, PA

MEDICAL SEMINAR SERIES - 1:00 - 4:00 P.M.

Sept. 7: AIDS and AIDS Related
 Infections
 Oct. 4: Osteoporosis

Oct. 19: Dept. of Medicine Resident
 Alumni Research Seminar
 Oct. 26: Anti-Coagulation Therapy &
 Disorders of Coagulation

Nov. 2: Treatment of Hypertension
 Nov. 30: Management of Hyperlipidemia
 Dec. 7: Valvular Heart Disease

WATCH FOR FUTURE ANNOUNCEMENTS!!

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 William S. Frankl, M.D.
 Professor of Medicine
 Chairman, Dept. of Medicine

Allan B. Schwartz, M.D.
 Professor of Medicine, Deputy Chairman
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in cooperation with Temple University School of Medicine, Department of Neurology
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Moderator: Stephen D. Silberstein, M.D.
Chief, Neurology Section & Co-Director,
The Comprehensive Headache Center,
The Germantown Hospital and Medical Center;
Associate Professor of Neurology, Temple University

Saturday, October 1, 1988 8:30 A.M.–3:15 P.M.
at The Germantown Hospital and Medical Center

One Penn Boulevard, Philadelphia, Pa.
(adjacent to LaSalle University at the intersection
of Wister, Chew and Olney Avenues)

Featured Speakers and Topics:

Welcoming Remarks

Edward Jones, M.D.
Chief, Nephrology Section &
Deputy Chairman, Department of Medicine,
The Germantown Hospital and Medical Center

Drug Induced Headaches

Ninan T. Mathew, M.D.
Clinical Associate Professor of Neurology,
University of Texas;
Director, Houston Headache Center

Sexual and AIDS-Related Headaches

Jerome Goldstein, M.D.
Associate Clinical Professor of Neurology,
University of California at San Francisco

A Unifying Concept of Migraine Mechanisms

K.M.A. Welch, M.D.
Professor & Chairman, Department of Neurology,
Henry Ford Hospital, Detroit, Michigan

Depression in the Headache Population

Gregory J. Tramuta, M.D.
Associate Clinical Professor of Psychiatry,
Temple University Hospital;
Chief of Psychiatry,
The Germantown Hospital and Medical Center

Additional participants will include:

Elliott A. Schulman, M.D., Attending Neurologist, The Germantown Hospital and Medical Center; Assistant Professor of Neurology, Temple University; Fellow of the American Academy of Neurology.

Ronald S. Kaiser, Ph.D., Licensed Clinical Psychologist; Affiliate, Psychiatry Section, The Germantown Hospital and Medical Center; Clinical Assistant Professor of Psychology, Hahnemann University; Adjunct Associate Professor of Psychology, Temple University.

Joseph P. Primavera, III, M.A., Licensed Clinical Psychologist; Affiliate, Psychiatry Section, The Germantown Hospital and Medical Center; Co-Director, The Biofeedback Laboratory.

A roundtable discussion will include controversial topics in headache management and difficult cases.

*Plan to bring your difficult cases for discussion.

Credits:

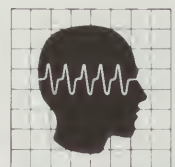
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the AMA Physician's
Recognition Award and
5 Category I credits for the
American Psychologists
Association.

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The Comprehensive Headache Center
The Germantown Hospital and Medical Center
One Penn Boulevard, Philadelphia, PA 19144



**COMPREHENSIVE
HEADACHE CENTER**

The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization for further information.

This list is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the UMDNJ Office of Continuing Medical Education. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ALLERGY

October

- 5 Food Allergy**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

November

- 6- In Vitro Allergy Seminar: Update 1988**
Various times—Trump Plaza Hotel and Casino, Atlantic City
(Holy Name Hospital)
- 11 Asthma and Allergies**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton
(Bridgeton Hospital)

ANESTHESIOLOGY

November

- 2 Pain Therapy**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)
- 15 Anesthesia and the Burn Patient**
6-9 P.M.—Ramada Inn, Clark
(NJ State Society of Anesthesiologists)
- 15 NJSSA—General Membership Meeting**
6-10 P.M.—Ramada Inn, Clark
(NJSSA)

CARDIOLOGY

October

- 5 Advanced Cardiac Life Support**
6 P.M.—Freehold Area Hospital, Freehold
(Freehold Area Hospital)
- 11 Cholesterol Reduction and Cardiovascular Issues**
10:30-11:30 A.M.—West Hudson Hospital, Kearny
(West Hudson Hospital)
- 11 Indications for Invasive Studies**
12 noon-1 P.M.—Hospital Center at Orange
(AMNJ)
- 18 Thrombolytic Therapy in the 1980s**
7:30-8:30 P.M.—Mercer Medical Center, Trenton
(Mercer Medical Center)
- 26 The Prevention of Sudden Cardiac Death**
8:15 A.M.-6 P.M.—Vista Hotel, Elizabeth
(UMDNJ)

November

- 7 Advanced Cardiac Life Support**
6 P.M.—Freehold Area Hospital, Freehold
(Freehold Area Hospital)
- 15 Thromboembolism and Thrombolytic Therapy**
12 noon-1 P.M.—Hospital Center at Orange
(AMNJ)
- 17 Indications for Noninvasive Studies**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

DERMATOLOGY

October

- 4 Diagnosis and Management of Cutaneous Disorders of the Newborn**
8:30-9:30 A.M.—Newark Beth Israel Medical Center, Newark
(Newark Beth Israel Medical Center)
- 6 Common Dermatoses**
11 A.M.-12 noon—St. Joseph's Hospital and Medical Center, Paterson
(AMNJ)
- 11 Dermatological Society of New Jersey**
7-10 P.M.—Schering-Plough Corporation, Kenilworth
(Dermatological Society of New Jersey)
- 19 Dermatology Conferences**
6-9 P.M.—Rutgers Community Health Plan, 57 U.S. Highway 1, New Brunswick
(UMDNJ)
- 19 Insights into Clinical and Investigative Pediatric Dermatology**
12 noon-6:30 P.M.—Robert Wood Johnson Medical School, Medical Education Building, New Brunswick
(UMDNJ)
- 26 Dermatology 1988**

8 A.M.-4:30 P.M.—Medical Center of Learning Auditorium, Englewood Hospital, Englewood
(Englewood Hospital)

November

- 8 Dermatological Society of New Jersey**
7-10 P.M.—Schering-Plough Corporation, Kenilworth
(Dermatological Society of New Jersey)
- 15 Update of Superficial Fungal Infections**
2-3 P.M.—Hunterdon Developmental Center, Clinton
(AMNJ)
- 16 Dermatology Conferences**
6-9 P.M.—Rutgers Community Health Plan, 57 U.S. Highway 1, New Brunswick
(UMDNJ)

MEDICINE

October

- 4 Hirsutism**
7-8 P.M.—West Hudson Hospital, Kearny
(West Hudson Hospital)
- 4 Ethical Challenges in Developmental Medicine**
10-11 A.M.—Green Brook Regional Center, Green Brook
(AMNJ)
- 5 Common ENT Problems**
1:30-2:30 P.M.—HMO, New Brunswick
(Rutgers Community Health Plan)
- 5 AIDS: Diagnosis and Treatment**
1:30 P.M.-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)
- 5 What Can the Primary Care Physician Do About Obesity?**
9-10:30 A.M.—Somerset Medical Center, Somerville
(Somerset Medical Center)
- 5 Care for the Dying Patient**
1:30-2:30 P.M.—RCHP, 57 U.S. Highway 1, New Brunswick
(Rutgers Community Health Plan)
- 5 Intensive Review of Medicine**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth
(Cornell University Medical College and the National Institutes of Health)
- 5 Sports Medicine 1988**
9 A.M.-1:15 P.M.—Medical Society of New Jersey headquarters, Lawrenceville
(MSNJ)
- 5 Medical Lecture Series**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(Christ Hospital)
- 8 Medical History Society of New Jersey**
10 A.M.-2 P.M.—UMDNJ, Newark
(Medical History Society of NJ)
- 11 Running the Health Care Practice Like a Business**
8-10 A.M.—The Union Hotel, Flemington
(Zdenek, Horvath and Scebelo)
- 11 Medical Grand Rounds**

THE PHILADELPHIA HEART INSTITUTE
of Presbyterian-University of Pennsylvania Medical Center

CARDIOLOGY UPDATE

designed for the physician and provides an intensive survey of the
current status of clinical cardiology

Wednesday
October 5, 1988
3:00 to 5:30 PM

**The Management of
Acute Myocardial Infarction**

Moderator
Bernard L. Segal, M.D.

- 3:00-3:30** When is Aggressive Intervention Indicated in Acute Myocardial Infarction? Thomas H. Kreulen, M.D.
3:30-4:00 Which Thrombolytic Agent Should Be Used in Patients With Acute Myocardial Infarction? J. David Ogilby, M.D.
4:00-5:00 Case Presentations Charles C. Cummings, M.D.
Panel Discussion Michael S. Feldman, M.D.
Garos S. Garibian, M.D., Robert Katz, M.D.
Kenneth D. Mendel, M.D., Henry S. Sawin, M.D.

- No Registration Fee
- Reception following session
- CME Credits*
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* The University of Pennsylvania School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing education for physicians. The University of Pennsylvania School of Medicine designates this continuing medical activity for 2 credit hours per session in Category I of the Physicians Recognition Award of the AMA.

- 18** 9-10 A.M.—Holy Name Hospital,
25 Teaneck
(*Holy Name Hospital*)
- 13** **General Use of Opiate Analgesics and Future Directions**
11 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(*St. Joseph's Hospital and Medical Center*)
- 17** **Morbidity/Mortality**
8-9 A.M.—West Hudson Hospital, Kearny
(*West Hudson Hospital*)
- 18** **Evolving Goals of Hypertensive Therapy**
9-10 A.M.—Holy Name Hospital, Teaneck
(*Holy Name Hospital*)
- 18** **Physical Assessment of the Severely Disabled**
11 A.M.-12 noon—Hunterdon Developmental Center, Clinton
(*AMNJ*)
- 19** **Refresher Course**
8 A.M.-4:30 P.M.—Princeton Ramada Inn, Princeton
(*NJ Academy of Family Physicists*)
- 19** **Governor's Conference on Clinical Prevention in Primary Care**
9 A.M.-5 P.M.—UMDNJ, New Brunswick
(*UMDNJ*)
- 19** **Geriatrics 1988**
8 A.M.-4 P.M.—Somerset Medical Center, Somerville
(*Somerset Medical Center*)
- 19** **AIDS**
1:30-5 P.M.—Overlook Hospital, Summit
(*NJ Gastroenterological Society*)
- 19** **Human Immunodeficiency Virus: Biology, Pathogenesis, and Treatment**
3:30-5:30 P.M.—Drew University Campus, Madison
(*Drew University and Ciba-Geigy Pharmaceuticals Division*)
- 20** **Proper Use of Antibiotics**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammondon
(*AMNJ*)
- 20** **Expanding Concepts of Channel Blocker Usage**
12 noon-1:30 P.M.—Somerset Medical Center, Somerville
(*Somerset Medical Center*)
- 21** **Ethical Challenges in Developmental Medicine**
1-2 P.M.—Woodbine Developmental Center, Woodbine
(*AMNJ*)
- 22** **Before You Borrow—A Prescription for Practice Start Up**
9 A.M.—New Jersey Medical School, Newark
(*UMDNJ*)
- 25** **The Misdiagnosed Headache**
7:30-8:30 P.M.—The Hyatt, East Brunswick, and Molly Pitcher Inn, Red Bank
(*The TMJ Trauma and Headache Center*)
- 26** **Practical Aspects of Office Management of Diabetes**
8 A.M.-1 P.M.—Glen Point Hotel,

- Teaneck
(*American Diabetes Association*)
- 26** **Cardiopulmonary Resuscitation**
1:30-2:30 P.M.—RCHP, 57 U.S. Highway 1, New Brunswick
(*Rutgers Community Health Plan*)
- 27** **What Works and Doesn't Work in Type II Diabetes**
11 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(*St. Joseph's Hospital and Medical Center*)
- 28** **Sports Injuries of the Lower Extremities**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton
(*Bridgeton Hospital*)

November

- 2** **Infections in the Elderly**
8:15 A.M.—Center for Health Affairs, Princeton
(*UMDNJ*)
- 2-** **New Leads into Cellular Processes**
- 4** 9 A.M.-5 P.M.—UMDNJ, Piscataway
(*UMDNJ*)
- 2** **Emergency Care**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(*AMNJ*)
- 2** **Cholesterol**
9-10:30 A.M.—Somerset Medical Center, Somerville
(*Somerset Medical Center*)
- 3** **Extracorporeal Shock Wave Lithotripsy**
11 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(*St. Joseph's Hospital and Medical Center*)
- 4** **Recent Advances in the Management of Epilepsy**
Robert Wood Johnson Medical School, New Brunswick
(*UMDNJ*)
- 4** **Calcium Blockers and the Kidney**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton
(*Bridgeton Hospital*)
- 6-** **In Vitro Allergy Seminar**
- 9** Trump Plaza Hotel and Casino, Atlantic City
(*Holy Name Hospital*)
- 7-** **Clinichem 1988**
- 8** 9 A.M.-5 P.M.—Sheraton Tara, Springfield, MA
(*Northeast Alliance of the American Association for Clinical Chemistry*)
- 8** **Uses of New B-Lactam Antibiotics**
9-10 A.M.—Holy Name Hospital, Teaneck
(*Holy Name Hospital*)
- 9** **Rational Use of Antibiotics**
7-9 P.M.—The Villa Mattar, Allamuchy
(*Hackettstown Community Hospital*)
- 9** **Clinical Management of HIV Infection**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(*AMNJ*)
- 9** **Brain Death**
1-2 P.M.—West Hudson Hospital, Kearny

- (*West Hudson Hospital*)
- 9** **Medical Lecture Series**
- 16** 10:30-11:30 A.M.—Christ Hospital, Jersey City
(*Christ Hospital*)
- 10** **Clinical Update in the Management of the Critically Ill Patient**
8 A.M.-5 P.M.—The Hyatt, Cherry Hill
(*NJ Society of Critical Care Medicine*)
- 10** **Management of Continuous Ambulatory Peritoneal Dialysis**
1:30-2:30 P.M.—Vineland Developmental Center, Vineland
(*AMNJ*)
- 10** **New Jersey Society of Critical Care Medicine**
Hyatt, Cherry Hill
(*NJ Society of Critical Care Medicine*)
- 15** **Malpractice**
10-11 A.M.—Green Brook Regional Center, Green Brook
(*AMNJ*)
- 15** **Immunology in Type I Diabetes**
9-10 A.M.—Holy Name Hospital, Teaneck
(*Holy Name Hospital*)
- 16** **Proper Use of Endoscopy**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(*AMNJ*)
- 16** **Pain Management**
1-2 P.M.—West Hudson Hospital, Kearny
(*West Hudson Hospital*)
- 16** **Evaluation and Management of Kidney Stones**
1:30-2:30 P.M.—RCHP, 57 U.S. Highway 1, New Brunswick
(*Rutgers Community Health Plan*)
- 16** **Annual Scientific Meeting of the Academy of Ophthalmology and Otolaryngology**
8 A.M.-4:30 P.M.—Aspen Conference Center, Parsippany
(*Academy of Ophthalmology and Otolaryngology*)
- 17** **Modern Management of Arthritis**
12 noon-1:30 P.M.—Somerset Medical Center, Somerville
(*Somerset Medical Center*)
- 18** **E.C.R.P.**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton
(*Bridgeton Hospital*)
- 29** **Relationship Between Aspirin and Bronchial Asthma**
9-10 A.M.—Holy Name Hospital, Teaneck
(*Holy Name Hospital*)
- 29** **Septic Shock**
12 noon-1 P.M.—Hospital Center at Orange
(*AMNJ*)
- 30** **New Physician Program**
8 A.M.-4:30 P.M.—MSNJ headquarters, Lawrenceville
(*MIENJ*)

NEPHROLOGY

October

- 18** **Potassium**
6:30-9 P.M.—Center for Community

THE ACADEMY OF MEDICINE OF NEW JERSEY
and

UMDNJ—NEW JERSEY MEDICAL SCHOOL
DEPARTMENT OF SURGERY

present
**A GENERAL SURGERY
REVIEW COURSE**

Friday, September 30 &
Saturday, October 1, 1988

7:45 A.M.-4:30 P.M.

at
**The Hilton at Short Hills
Short Hills, New Jersey**

This course is designed to give the participant an extensive review of the topics in general surgery and the surgical specialties that are likely to be covered on the American Board of Surgery Recertification Examination as well as the Qualifying (written) Examination of the Board.

It also will be of value to the practicing surgeon not studying for either of the examinations who desires an update on general surgery, or for the resident surgeon presently in a training program.

The course is designed to cover the topics from the viewpoint of clinical management and decision making, with basic science considerations added as they enhance the clinical perspective.

The distribution of time allotted to each particular topic will parallel the emphasis given to that topic by the Board in previous examinations.

PROGRAM DIRECTOR: GEORGE W. MACHIEDO, M.D.

Professor and Vice Chairman
Director of Clinical Surgery
UMDNJ University Hospital
Newark, New Jersey

*For Further Information on Registration,
Faculty and Fees, Please Contact:*

Genie Cox
Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, New Jersey 08648
Phone: (609) 896-1717



PEDIATRIC RADIOLOGY: A SPECIAL APPROACH

Tuesday, October 11, 1988 6 pm - 9:30 pm
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David V. Habif, Jr., M.D.
"Overview: Pediatric Radiology"

Edward M. Solomon, M.D.
"Advances in Pediatric Sedation"

John P. Amodio, M.D.
"Pediatrics & New Technology"

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Health, Overlook Hospital, Summit
(*Nephrology Society of
New Jersey*)

November

- 15** **Interventional Strategies in Diabetic Nephropathy**
6:30-9 P.M.—Overlook Hospital, Summit
(*Nephrology Society of
New Jersey*)

OBSTETRICS/GYNECOLOGY

October

- 12** **From Fetus to Newborn**
9:30-4:30 P.M.—Woodbridge Hilton Hotel, Woodbridge
(*Newark Beth Israel Medical Center*)

November

- 6-** **Third Annual Issues and Controversies in Obstetrics/Gynecology**
7 A.M.—Contemporary Hotel, Lake Buena Vista, Florida

ONCOLOGY

October

- 5** **Current Topics in Oncology**
12 noon-5 P.M.—Mayfair Farms, West Orange
(*Oncology Society of NJ*)
- 6** **Cancer Research Colloquium**
- 13** 3-4 P.M.—New Jersey Medical School, G-506B, Newark
(*UMDNJ*)
- 20** **Tumor Conference**
12 noon-1 P.M.—Community Memorial Hospital, Toms River
(*Community Memorial Hospital*)
- 27** **Tumor Board Conference**
12 noon-1 P.M.—Newcomb Medical Center, Vineland
(*Newcomb Medical Center*)

November

- 3** **Cancer Research Colloquium**
- 10** 3-4 P.M.—New Jersey Medical School, G-506B, Newark
(*UMDNJ*)
- 17** **Colon-Rectal Cancer**
7-8 P.M.—Walkill Valley General Hospital, Sussex
(*AMNJ*)
- 14** **Tumor Board Conferences**
12 noon-1 P.M.—Newcomb Medical Center, Vineland
(*Newcomb Medical Center*)

PSYCHIATRY

October

- 6** **Fits, Faints, and Facsimiles: Psychiatric Aspects of Epilepsy**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)
- 13** **Polymyalgia Rheumatica/Temporal Arthritis: The Great Imposters**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)
- 26** **Middle Age and Health**

9 A.M.-5 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)

November

- 1** **Divorce and Custody: Impact on Children and Parents**
8:30-9:30 A.M.—Newark Beth Israel Medical Center, Newark
(*Newark Beth Israel Medical Center*)
- 2** **Case Seminars To Improve Psychotherapeutic Technique**
8-10 P.M.—2 West Northfield Road, Livingston
(*Advanced Psychiatric Study Group*)
- 16** **Indications for Family Therapy**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)
- 10** **Supportive Psychotherapy**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)
- 16** **AIDS: The Brain on Fire**
9 A.M.-5 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)
- 17** **Family Therapy with Adolescents**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)

PULMONARY

October

- 4** **Pulmonary Conferences**
- 11** 8-9 A.M.—New Jersey Medical School, H-349, Newark
(*UMDNJ*)
- 18** **Pulmonary Case Conferences**
- 25** 8-9 A.M.—University Hospital, New Brunswick
(*UMDNJ*)

November

- 1** **Pulmonary Conferences**
- 8** 8-9 A.M.—New Jersey Medical School, H-349, Newark
(*UMDNJ*)
- 15** **Pulmonary Case Conferences**
- 22** 8-9 A.M.—University Hospital, New Brunswick
(*UMDNJ*)
- 29**

RADIOLOGY

October

- 11** **Pediatric Radiology**
6-9:30 P.M.—The Meeting Place, Hackensack
(*Teaneck Radiology Center*)
- 20** **Interventional Radiology, Help or Hindrance to the Vascular Surgeon**
5-6 P.M.—Shore Memorial Hospital, Somers Point
(*Shore Memorial Hospital*)

November

- 10** **Radiological Society of New Jersey Meeting**
7:30-9:30 P.M.—Saint Barnabas

Medical Center, Livingston
(*Radiological Society of NJ and AMNJ*)

30 Dinner Meeting

6:30-9:30 P.M.—The Manor, West Orange
(*Radiation Oncology Section—AMNJ*)

SURGERY AND SURGICAL SPECIALTIES

October

- 1** **General Surgical Review Course**
7:45-4:30 P.M. (starting September 30)—Hilton, Short Hills
(*AMNJ*)
- 11** **Surgical Grand Rounds**
7-9 A.M.—Hackensack Medical Center, Hackensack
(*Hackensack Medical Center*)
- 17** **Surgical Series**
8-9 A.M.—West Hudson Hospital, Kearny
(*West Hudson Hospital*)
- 25** **Treatment of Impotency by Injection**
8-10 P.M.—Englewood Club, Englewood
(*Englewood Surgical Society*)

November

- 1** **Surgical Grand Rounds**
- 15** 7-9 A.M.—Hackensack Medical Center, Hackensack
(*Hackensack Medical Center*)
- 22** **Microvascular Surgery**
6:30-10:30 P.M.—The Manor, West Orange
(*Vascular Society of New Jersey*)
- 29** **Surgical Series**
8-9 A.M.—West Hudson Hospital, Kearny
(*West Hudson Hospital*)
- 21** **Update on the Management of Surgical Infections**
8-10 P.M.—Englewood Club, Englewood
(*Englewood Surgical Society*)

UROLOGY

October

- 12** **Urology Rounds**
6:20-8:30 P.M.—Robert Wood Johnson Medical School, 108B, New Brunswick
(*UMDNJ*)
- 19** **Second General Lithotripter**
6-7 P.M.—Forsgate Country Club, Jamesburg
(*Mid-Atlantic Kidney Stone Center*)

November

- 9** **Urology Rounds**
6:20-8:30 P.M.—Robert Wood Johnson Medical School, 108B, New Brunswick
(*UMDNJ*)
- 16** **Evaluation and Management of Kidney Stones**
1:30-2:30 P.M.—HMO, New Brunswick
(*Rutgers Community Health Plan*)



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Allan B. Schwartz, M.D.
Professor of Medicine and
Deputy Chairman
Graduate Medical Education

September 7, 1988

AIDS and AIDS Related Infections

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Abdolghadar Molavi, M.D.

Faculty:

Emily A. Blumberg, M.D.

David H. Gillespie, M.D.

Martin S. Hirsch, M.D.

Henry Masur, M.D.

Maggie Schultz, Ph.D.

David R. Strayer, M.D.

October 4, 1988

Osteoporosis

Course Director:

Vincent J. Zarro, M.D., Ph.D.

Faculty:

Maurice F. Attie, M.D.

Louis V. Avioli, M.D.

Doris G. Bartuska, M.D.

Arnold T. Berman, M.D.

Arthur Olshan, M.D.

October 19, 1988

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Faculty:

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Arthur Forman, M.D.

Robert Goldszer, M.D.

David O. Williams, M.D.

Gerald Winnan, M.D.

October 26, 1988

Anticoagulation Therapy

Course Director:

Isadore Brodsky, M.D.

Anticoagulation Therapy (cont'd)

Faculty:

James Conroy, D.O.

S. Benham Kahn, M.D.

Victor Marder, M.D.

Yale Nemerson, M.D.

Stephen R. Porter, M.D.

November 2, 1988

Treatment of Hypertension

Course Director:

Charles D. Swartz, M.D.

Faculty:

Norman Kaplan, M.D.

Martin B. Leon, M.D.

Arthur Olshan, M.D.

Allan B. Schwartz, M.D.

Barry F. Uretsky, M.D.

November 30, 1988

Management of Hyperlipidemia

Course Director:

Stuart Snyder, M.D.

Faculty:

Basil M. Rifkind, M.D.

Stanley J. Russin, Jr., M.D.

Mark F. Victor, M.D.

December 7, 1988

Valvular Heart Disease

Course Director:

William S. Frankl, M.D.

Faculty:

Stanley K. Brockman, M.D.

Demetrios Kimbiris, M.D.

Abdolghadar Molavi, M.D.

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Allergy, Principles and Practice; Color Doppler in Clinical Cardiology; Management of Common Problems in Obstetrics and Gynecology

Allergy, Principles and Practice. Vol. I and II. Third Edition

Elliot Middleton, Jr., M.D., Charles E. Reed, M.D., Elliot F. Ellis, M.D., et al., (eds). St. Louis, MO, C.V. Mosby Company, 1988.

This is a wonderfully updated text for those interested in allergy and immunology from basics to detailed clinical problems. The book is divided into two volumes: the first volume deals with basic sciences and the second volume deals with the clinical significance of various allergic and immunologic disorders including asthma.

The updating of this text has been performed meritoriously under the editorship of Elliot Middleton, with appropriate updates of all chapters as compared to the previous edition. The text is well written with current references and excellent tables, figures, and photographs.

I highly recommend this book to all practicing allergists and immunologists as well as those who have any interest in the basic sciences, or direct patient care, or for general expansion of knowledge in this area.

Leonard Bielory, M.D.

Color Doppler in Clinical Cardiology

Walter J. Duncan, M.D. Philadelphia, PA, W.B. Saunders Company, 1988. Pp. 163. (\$95)

This is a short and very well-illustrated text describing the new technology of color flow doppler imaging, a technique which combines noninvasive flow imaging with standard two-dimensional intracardiac imaging. The first of its five chapters is oriented to the reader who has only a basic knowledge of physics. Included in the first chapter of the text is a review of techniques to assess pulmonary flow and intracardiac shunts.

The chapter entitled, "Examination of the Color Doppler Technique," attempts to familiarize the reader with the author's combined two-dimensional and color doppler examination. A basic knowledge of two-dimensional echocardiography is necessary.

With its wide range of case studies, the book takes the form of a text atlas. The first set of case studies is devoted to pediatric abnormalities and the second set of case studies is devoted to adult diseases. The book ends with a short presentation of case studies of intraoperative imaging.

The text is clear and concise and the photographs are of excellent quality. The book is highly recommended for the physician who has a working knowledge of two-dimensional echocardiography and wishes to utilize this technique in his ultrasonographic examination.

Neil B. Horner, M.D.

Management of Common Problems in Obstetrics and Gynecology

Daniel R. Mitchell, Jr., M.D., Paul F. Brenner, M.D., (eds). Oradell, NJ, Medical Economics Books, 1988.

It is an awesome responsibility to review a textbook edited by authorities bearing titles of full professor, chairman, and vice-president. It is almost presumptuous to critique a second edition of a compendium that covers practically every common problem in our discipline, and that is recommended by a dean and vice-chancellor for almost everybody. There are errors of commission and

omission in *Management of Common Problems in Obstetrics and Gynecology* which cannot be ignored.

False negative cytology has received much publicity this year. There is no excuse for the authors to adhere to an outmoded nomenclature that is the hallmark of the "Pap mills" that probably are responsible for most of the false negatives, notwithstanding "laboratory error accounts for a small number of cytology misses." This statement appears almost insignificant compared to thousands of accurate statements but nothing has discredited this most rapid, cost-effective method of cervical cancer screening than the false-negative scandal.

Frequent radiologic reports of mammary dysplasia are vexatious for the clinician while the academician is touting estrogens for nearly every postmenopausal woman without cancer. Mammary dysplasia deserves authoritative advice.

Most research into oral contraceptives reports triglyceride elevations after one year. The authors not only fail to mention this, but advise uninterrupted use for years.

Three simple office procedures should precede expensive, time-consuming workups: (1) a postcoital test for infertility; (2) catheterization for residual urine in cases of stress incontinence; (3) a three-month trial of oral contraceptives for suspected endometriosis unless contraindications exist.

Despite the dean's blessing, this edition cannot be recommended wholeheartedly to students because many of the authors presume so much background experience and education that many of their contributions are not entirely meaningful and intelligible. If a third edition is prepared, hopefully the editors will read every word contributed by their experts as well as the galley proofs, keeping the student and the older practitioner in mind. Slang may be effective in the lecture hall, but rarely in print.

This book is recommended especially for the resident overconfident after a year of manual training, and preparing to meet examiners resistant to contradiction.

Jerome Abrams, M.D., M.P.H.



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Governor Thomas H. Kean (right) signs bill into law as New Jersey State Medical Underwriter Inc. President Peter Sweetland (left) and Chairman Henry J. Mineur, M.D. (center) look on.

Drs. Abey; Dierwechter; Fidler; Filipczak; Hallock; Kearney; Knapp; Latona; Lobban; Murphy; Neville; Pindar; Ricciardelli; Stier; Strom; Trilling

Dr. William J. H. Abey

Pennington family practitioner William J. H. Abey, M.D., died on April 26, 1988, at the age of 87. Born in Manitoba, Canada, Dr. Abey was graduated from McGill University Faculty of Medicine, Montreal, in 1926. He resided in Pennington for 50 years, where he maintained his practice, before moving to Florida 12 years ago. Dr. Abey was a veteran of the Royal Canadian Air Force. In 1976, Dr. Abey received the Medical Society of New Jersey's Golden Merit Award for 50 years of service to his medical community.

Dr. R. James Dierwechter

Brigantine family physician R. James Dierwechter, M.D., died on April 29, 1988, at the age of 76. Born in Philadelphia, Dr. Dierwechter received his medical degree from Hahnemann Medical College and Hospital, Pennsylvania, in 1940. A fellow of the American Academy of Family Practice, Dr. Dierwechter was a member of our Atlantic County component and of the American Medical Association. A Brigantine area resident and physician for over

40 years, Dr. Dierwechter became affiliated with Atlantic City Medical Center, and became public school physician for Brigantine. During World War II, he served in the United States Army medical corps as a physician, emerging with the rank of lieutenant colonel.

Dr. Harry E. Fidler

Retired otolaryngologist Harry Earl Fidler, M.D., died on April 27, 1988, at the age of 68. Born in Hooversville, Pennsylvania, Dr. Fidler received his medical degree from Jefferson Medical College of Philadelphia, in 1946. A diplomate in otolaryngology, Dr. Fidler was affiliated with St. Peter's Medical Center, New Brunswick, and was a member of our Middlesex County component and of the AMA. During World War II, he was a captain in the United States Army.

Dr. Borys A. Filipczak

General surgeon Borys Anthony Filipczak, M.D., died on May 16, 1988, at the age of 80. A native of Sambir, in the Ukraine, Dr. Filipczak received his medical degree from the University of Cracow, Poland, in 1931. He emigrated to the United States in 1949, and from 1950 to 1955, maintained a practice in Toledo, Ohio. In 1955, Dr. Filipczak moved to Passaic, where he set up a private practice, and became affiliated with three Passaic hospitals: St. Mary's Hospital, Beth Israel Hospital, and the General Hospital Center. A fellow of the International College of Surgeons, Dr. Filipczak was a member of our Passaic County component and of the American Medical Association.

Dr. Wilton J. Hallock

Obstetrician-gynecologist Wilton Johnson Hallock, M.D., died on May 18, 1988, at the age of 89. A native of Jersey City, Dr. Hallock received his medical degree from New York Medical College in 1924. A fellow of the New Jersey Obstetric and Gynecological Society, Dr. Hallock was a member of our Union County component and of the AMA, as well as a staff member of Overlook Hospital, Summit. He is a veteran of the United States Army. In 1974, Dr. Hallock received the Medical Society of New Jersey's Golden Merit Award for 50 years as a physician.

Dr. John F. Kearney

Retired family practitioner John Francis Kearney, M.D., died on April 22, 1988, at the age of 82. Born in Scranton, Pennsylvania, Dr. Kearney received his medical degree at Columbia University College of Physicians and Surgeons, New York, in 1932. He maintained a private practice in Maplewood and was affiliated with St. Michael's Medical Center, Newark, before retiring. He was a lieutenant colonel in the United States Army during World War II, serving as a regimental surgeon for the 335th Engineer's Regiment in the European theatre. Dr. Kearney received MSNJ's Golden Merit Award in 1982.

Dr. Victor Knapp

Asbury Park family physician Victor Knapp, M.D., 88, died on April 22, 1988. A native of New York, Dr. Knapp received his medical degree from New York University School of Medicine, in 1921. He moved to Asbury Park in 1931, and maintained a private practice there for 57 years. Dr. Knapp became affiliated with Monmouth Memorial Hospital, Long Branch, and broadcast a weekly radio show, "Medical Topics," for over 20 years. He was a member of our Monmouth County component and of the AMA. Dr. Knapp was a recipient of MSNJ's Golden Merit Award in 1971.

Dr. Joseph A. Latona

General surgeon Joseph A. Latona, M.D., died on May 25, 1988, at the age of 84. Born in Palermo, Sicily, Dr. Latona received his medical degree at Cornell University Medical College, New York, in 1928. Affiliated with St. Mary's Hospital, Passaic, for 55 years, serving as both trustee and chief of tumor services, Dr. Latona maintained a medical practice in Lodi for 60 years. A fellow of the American College of Surgeons, Dr. Latona was a member of our Bergen County component and of the AMA. He was a 1978 recipient of the Golden Merit Award.

Dr. Robert B. Lobban

Robert B. Lobban, M.D., retired from surgery practice since 1972, died on May 26, 1988, at the age of 84. Born in Alderson, West Virginia, Dr. Lobban received his medical

degree from the University of Virginia Medical School in 1929. A diplomate in surgery and a fellow of the American College of Surgeons, Dr. Lobban was a member of our Hudson County component and of the AMA. Affiliated with Christ Hospital, Jersey City, he served as chief of surgery. Dr. Lobban also had maintained a private surgical practice since 1945. During World War II, Dr. Lobban was a colonel in the United States Army medical corps stationed in the South Pacific Islands. In 1979, he received MSNJ's Golden Merit Award.

Dr. Joseph P. Murphy

Family physician and specialist in internal medicine Joseph Paul Murphy, M.D., died on March 2, 1988, at the age of 64. Born in Newark, Dr. Murphy received his medical degree from the University of Amsterdam, the Netherlands, in 1958. He became affiliated with Warren Hospital, Phillipsburg, and was a member of our Warren County component and of the AMA. During World War II, he served in the United States Navy medical corps.

Dr. Robert J. Neville

Retired orthopedic surgeon Robert Jerome Neville, M.D., died on May 12, 1988, at the age of 78. A Brooklyn, New York, native, Dr. Neville received his medical degree from the Long Island College of Medicine, New York (now the Medical College of the State University of New York), in 1934. A diplomate in orthopedic surgery, Dr. Neville was a fellow of the American and International Colleges of Surgeons, and was a member of our Bergen County component and of the AMA. In addition to his Hackensack private practice, Dr. Neville was affiliated with Hackensack Medical Center, serving in many capacities: as director of the departments of orthopedic and traumatic surgery, and rehabilitative medicine; as chairman

of the medical executive board; and as the first director of the emergency department. Dr. Neville was orthopedic director for the National Foundation for Infantile Paralysis during the polio outbreak in the late 1940s. During the Korean War, he was a lieutenant colonel in the United States Army. Dr. Neville served as president of the New Jersey Orthopedic Society, and of the Bergen County Medical Society. In 1984, he received the Golden Merit Award.

Dr. Irene D. Pindar

General practitioner Irene Donnelly Pindar, M.D., died on April 19, 1988, at the age of 85. Born in Dayton, Ohio, Dr. Pindar received her medical degree from the University of Cincinnati, Ohio, in 1926. She operated a private practice in Teaneck for 50 years, and was affiliated with Holy Name Hospital, Teaneck, and Englewood Hospital. For 50 years as a physician, Dr. Pindar received MSNJ's Golden Merit Award in 1976.

Dr. E. F. Ricciardelli

Retired family practitioner Emmanuel Frederick Ricciardelli, Sr., M.D., died on June 1, 1988, at the age of 85. A lifelong resident of Jersey City, Dr. Ricciardelli received his medical degree from Temple University School of Medicine, Philadelphia, Pennsylvania, and opened a Jersey City private practice which he maintained for over 50 years. During World War II, Dr. Ricciardelli served as a captain in the United States Army medical corps. He was a member of our Hudson County component and of the AMA.

Dr. Howard W. Stier

General surgeon and practitioner Howard William Stier, M.D., 69, died on May 31, 1988, after 42 years of practice in Passaic. Born in Clifton, Dr. Stier received his medical degree from the University of Maryland School of Medicine, Baltimore, in

1943. A lifelong Passaic-Clifton area resident, Dr. Stier opened a private practice in 1945, and began an affiliation with the General Hospital Center at Passaic the same year. While a staff member of the hospital, Dr. Stier was chairman of the executive committee, president of the medical and dental staff, director of surgery, director of the emergency room, and was a member of the Passaic General Foundation Board. In 1958, he was honored by being named "staff member of the year." Dr. Stier was a member of our Passaic County component.

Dr. Abraham Strom

Internal medicine specialist Abraham Strom, M.D., died on December 25, 1987, at the age of 99. A native of Russia, Dr. Strom received his medical degree from the University of Berne, Switzerland. He was affiliated with Muhlenberg Medical Center, Plainfield, and maintained a private practice there for over 50 years. Dr. Strom was a member of our Union County component and of the AMA. In 1967, he received MSNJ's Golden Merit Award.

Dr. Leonard J. Trilling

Retired dermatologist Leonard Jay Trilling, M.D., died on May 31, 1988, at the age of 80. A native of Paterson, Dr. Trilling received his medical degree at Columbia University College of Physicians and Surgeons, New York, in 1934. He maintained two dermatology practices, one in Paterson from 1945 to 1955, and another in New York City. Dr. Trilling was affiliated with St. Joseph Hospital and Medical Center, Paterson, where he served as head of the Dermatology Department before his retirement in 1965. At that time, Dr. Trilling moved to Washington, D.C., where he was employed by the United States Food and Drug Administration. He was a member of our Passaic County component and of the AMA.

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1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.
2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

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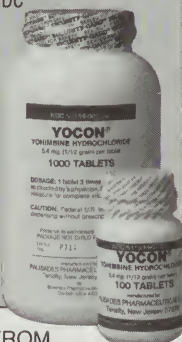
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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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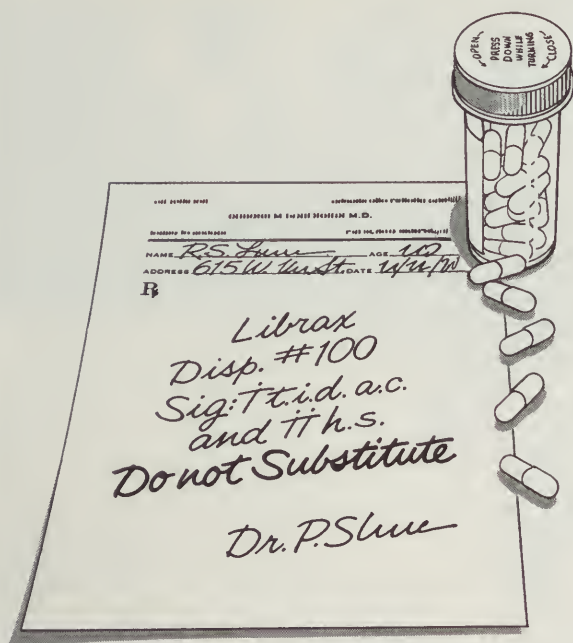
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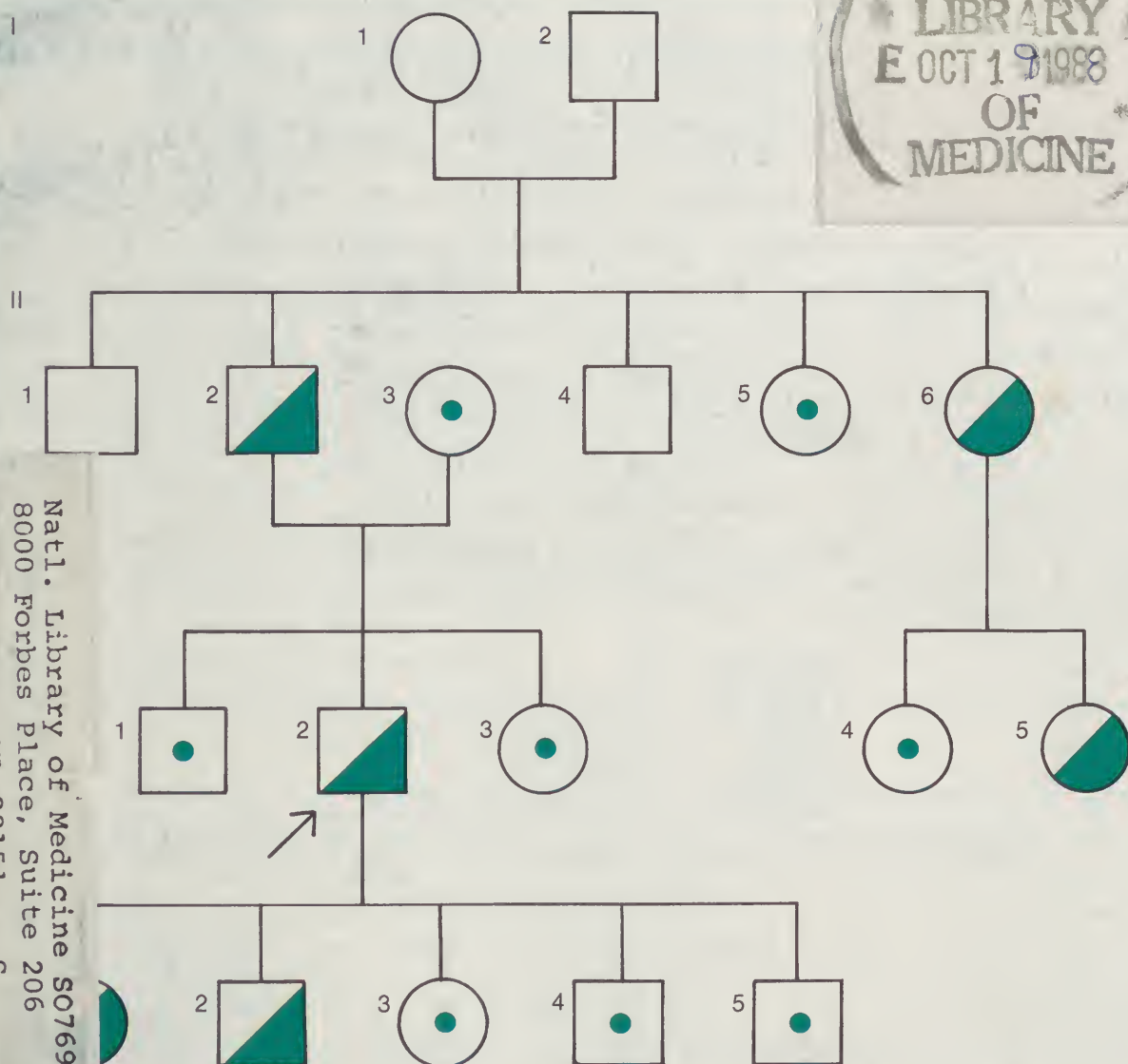
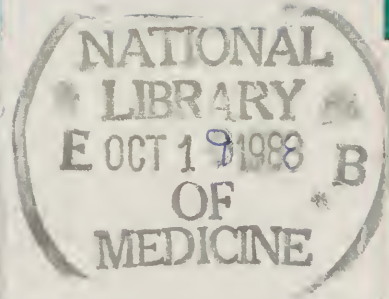
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October 1988

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Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β -hemolytic streptococci).

Contraindication: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Cecilor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Cecilor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in

moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.

- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Cecilor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Cecilor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%, and rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis: elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinistest[®] tablets but not with Tes-Tape[®] (glucose enzymatic test strip, Lilly).

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NEW JERSEY MEDICINE

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

OCTOBER 1988

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On The Cover: Six members of one family had low levels of protein C; age appeared to be the major determinant for the developing symptoms. The study begins on page 805.



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See following page for brief summary of prescribing information.

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THEOPHYLLINE (Anhydrous) Sustained Action Tablets

INDICATIONS: THEO-DUR is indicated for relief and/or prevention of symptoms of asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

CONTRAINDICATIONS: THEO-DUR is contraindicated in individuals who have shown hypersensitivity to theophylline or any of the tablet components.

WARNINGS: Status asthmaticus should be considered a medical emergency and is defined as that degree of bronchospasm which is not rapidly responsive to usual doses of conventional bronchodilators. Optimal therapy for such patients frequently requires both additional medication, parenterally administered, and close monitoring, preferably in an intensive care setting.

Although increasing the dose of theophylline may bring about relief, such treatment may be associated with toxicity. The likelihood of such toxicity developing increases significantly when the serum theophylline concentration exceeds 20 mcg/ml. Therefore, determination of serum theophylline levels is recommended to assure maximal benefit without excessive risk.

Serum levels above 20 mcg/ml are rarely found after appropriate administration of recommended doses. However, in individuals in whom theophylline plasma clearance is reduced for any reason, even conventional doses may result in increased serum levels and potential toxicity. Reduced theophylline clearance has been documented in the following readily identifiable groups: 1) patients with impaired renal or liver function; 2) patients over 55 years of age, particularly males and those with chronic lung disease; 3) those with cardiac failure from any cause; 4) neonates; and 5) those patients taking certain drugs (macrolide antibiotics and cimetidine). Decreased clearance of theophylline may be associated with either influenza immunization or active infection with influenza.

Reduction of dosage and laboratory monitoring is especially appropriate in the above individuals. Less serious signs of theophylline toxicity (i.e. nausea and restlessness) may occur frequently when initiating therapy, but are usually transient; when such signs are persistent during maintenance therapy, they are often associated with serum concentrations above 20 mcg/ml. Unfortunately, however, serious side effects such as ventricular arrhythmias, convulsions or even death may appear as the first sign of toxicity without any previous warning. Stated differently: serious toxicity is not reliably preceded by less severe side effects.

Many patients who require theophylline may exhibit tachycardia due to their underlying disease process so that the cause/effect relationship to elevated serum theophylline concentrations may not be appreciated.

Theophylline products may cause dysrhythmia and/or worsen pre-existing arrhythmias and any significant change in rate and/or rhythm warrants monitoring and further investigation.

The occurrence of arrhythmias and sudden death (with histological evidence of necrosis of the myocardium) has been recorded in laboratory animals (minipigs, rodents and dogs) when theophylline and beta agonists were administered concomitantly, although not when either was administered alone. The significance of these findings when applied to human usage is currently unknown.

PRECAUTIONS: THEO-DUR TABLETS SHOULD NOT BE CHEWED OR CRUSHED.

General: Theophylline half-life is shorter in smokers than in non-smokers. Therefore, smokers may require larger or more frequent doses. Morphine and curare should be used with caution in patients with airway obstruction as they may suppress respiration and stimulate histamine release. Alternative drugs should be used when possible. Theophylline should not be administered concurrently with other xanthine medications. Use with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, in the elderly (especially males) and in neonates. In particular, great caution should be used in giving theophylline to patients with congestive heart failure. Frequently, such patients have markedly prolonged theophylline serum levels with theophylline persisting in serum for long periods following discontinuation of the drug. Individuals who are rapid metabolizers of theophylline, such as the young, smokers, and some non-smoking adults, may not be suitable candidates for once-daily dosing. These individuals will generally need to be dosed at 12 hour or sometimes 8 hour intervals. Such patients may exhibit symptoms of bronchospasm near the end of a dosing interval, or may have wider peak-to-trough differences than desired.

Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to the G.I. tract although gastrointestinal symptoms are more commonly centrally mediated and associated with serum drug concentrations over 20 mcg/ml.

Information for Patients: The physician should reinforce the importance of taking only the prescribed dose and time interval between doses. THEO-DUR tablets should not be chewed or crushed. When dosing THEO-DUR on a once daily (24 hr) basis, tablets should be taken whole and not split. As with any controlled-release theophylline product, the patient should alert the physician if symptoms occur repeatedly, especially near the end of the dosing interval.

DRUG INTERACTIONS: Drug-Drug: Toxic synergism with epinephrine has been documented and may occur with some other sympathomimetic bronchodilators. In addition, the following drug interactions have been demonstrated:

Drug	Effect
Theophylline with lithium carbonate	Increased excretion of lithium carbonate
Theophylline with propranolol	Antagonism of propranolol effect
Theophylline with cimetidine	Increased theophylline blood levels
Theophylline with troleandomycin, erythromycin	Increased theophylline blood levels

Drug-Food: THEO-DUR 100 mg Sustained Action Tablets have not been adequately studied to determine whether their bioavailability is altered when given with food. Available data suggest that drug administration at the time of food ingestion may influence the absorption characteristics of theophylline controlled-release products resulting in serum values different from those found after administration in the fasting state.

A drug-food effect, if any, would likely have its greatest clinical significance when high theophylline serum levels are being maintained and/or when large single doses (greater than 13 mg/kg or 900 mg) of a controlled-release theophylline product are given.

THEO-DUR (200, 300, and 450 mg) Sustained Action Tablets: The rate and extent of absorption of theophylline from THEO-DUR 200 mg, 300 mg, and 450 mg tablets when administered fasting or immediately after a moderately high fat content breakfast is similar.

Drug-Laboratory Test Interactions: When plasma levels of theophylline are measured by spectrophotometric methods, coffee, tea, cola beverages, chocolate, and acetaminophen contribute falsely high values.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic potential, mutagenic potential, or the effect on fertility of xanthine compounds.

Pregnancy: Category C—Animal reproduction studies have not been conducted with theophylline. It is not known whether theophylline can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Xanthines should be given to a pregnant woman only if clearly needed.

Nursing Mothers: It has been reported that theophylline distributes readily into breast milk and may cause adverse effects in the infant. Caution must be used if prescribing xanthine to a mother who is nursing, taking into account the risk/benefit of this therapy.

Pediatric Use: Safety and effectiveness of THEO-DUR administered:

1. Every 24 hours in children under 12 years of age, have not been established.
2. Every 12 hours in children under 6 years of age, have not been established.

ADVERSE REACTIONS: The most consistent adverse reactions are usually due to overdose and are:

1. **Gastrointestinal:** nausea, vomiting, epigastric pain, hematemesis, diarrhea.
2. **Central nervous system:** headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions.
3. **Cardiovascular:** palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias.
4. **Respiratory:** tachypnea.
5. **Renal:** albuminuria, increased excretion of renal tubular and red blood cells, potentiation of diuresis.
6. **Other:** rash, hyperglycemia and inappropriate AOH syndrome.

OVERDOSEAGE; Management: If potential oral overdose is established and seizure has not occurred:

- A. Induce vomiting.
- B. Administer a cathartic (this is particularly important if sustained-release preparations have been taken).
- C. Administer activated charcoal.

If patient is having a seizure:

- A. Establish an airway.
- B. Administer oxygen.
- C. Treat the seizure with intravenous diazepam, 0.1 to 0.3 mg/kg up to 10 mg.
- D. Monitor vital signs, maintain blood pressure and provide adequate hydration.

Post Seizure Care:

- A. Maintain airway and oxygenation.
- B. If a result of oral medication, follow above recommendations to prevent absorption of the drug, but intubation and lavage will have to be performed instead of inducing emesis, and the cathartic and charcoal will need to be introduced via a large bore gastric lavage tube.
- C. Continue to provide full supportive care and adequate hydration while waiting for drug to be metabolized. In general, the drug is metabolized sufficiently rapid so as not to warrant consideration of dialysis; however, if serum levels exceed 50 mcg/ml charcoal hemoperfusion may be indicated.

CAUTION: Federal law prohibits dispensing without prescription. For full prescribing information, see package insert. Revised 6/87

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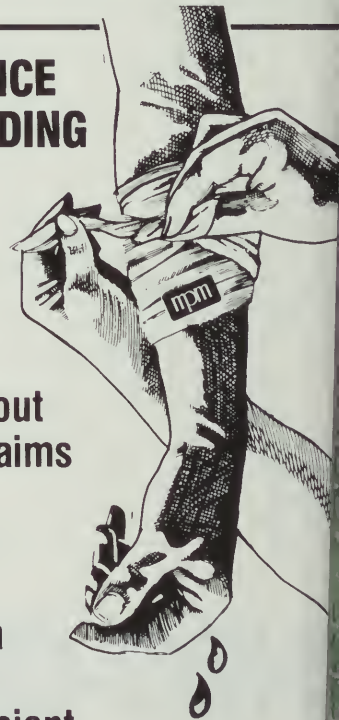
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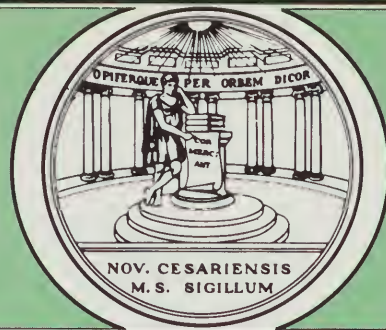


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MEMBERSHIP NEWSLETTER



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THE MEDICAL SOCIETY OF NEW JERSEY

Volume 59

MEDICAL SOCIETY OF NEW JERSEY Long-Term Care Insurance Program

The Committee on Membership Services has announced the following improvements under the MSNJ Long-Term Care Insurance Program:

- Enrollment now is open to individuals age 50 to 84.
- The maximum benefit amount increased to \$120 per day for up to six years of care.
- Full benefits are provided for skilled, intermediate, and custodial care.
- Home convalescent care benefits paid for up to two years at 50 percent of the daily benefit.
- A new inflation protection option is available.

Member physicians have received an explanatory brochure on this program and many have taken advantage of this important form of insurance protection. For members still considering the purchase of long-term care coverage, the new improvements should be of particular interest.

For more information on the many benefits of the improved MSNJ Long-Term Care Insurance Program, member physicians can write to the Committee's insurance consultant at: Donald F. Smith & Associates, PO Box 2197, Princeton, NJ 08543, or call Mr. Stan Farr at (609) 924-8700.

DEPARTMENT OF ENVIRONMENTAL PROTECTION Radon Outreach in New Jersey

In January 1986, legislation was passed appropriating funding for the State Departments of Environmental Protection (DEP) and Health (DOH) to address the radon issue statewide. This legislative appropriation mandated a statewide scientific study of radon (DEP), an epidemiological study (DOH), a confirmatory monitoring program (DEP), and a public information program (DEP and DOH).

In September 1987, DEP made recommendations for testing, based on initial study results from the statewide study as well as other criteria. These recommendations stress the potential for elevated radon levels in counties and municipalities in New Jersey:

- Tier I—All of Hunterdon, Sussex, and Warren counties as well as other municipalities; highest potential for elevated levels of radon. Recommendation: Test as soon as practical.
- Tier II—Potential exists; however, lower than Tier I. Recommendation: Test within one year.

- Tier III—Lowest incidence of elevated levels of radon. Recommendation: Test if concerned.

More than 75,000 calls have been made to the toll-free radon information line at 1/800/648-0394. Any resident concerned with the radon issue or wanting answers to questions should call this number to request an informational package. This package contains a letter to the homeowner explaining DEP's radon program; two U.S. Environmental Protection Agency (EPA) booklets, *A Citizens Guide to Radon* and *Radon Reduction Methods*; a listing of companies that offer radon testing and remediation services; and a brochure published by the Department of Health entitled *Facts and Recommendations on the Exposure to Radon*.

The EPA has established a guideline of 4 picocuries per liter (4 pCi/l) for indoor exposure to radon. Nationwide, the average level of indoor radon is believed to be 1 to 2 pCi/l. It has been estimated that over a million homes may be at risk for elevated levels of radon. If you test for radon and obtain a result of 4 pCi/l or greater, call the Radon Information Line to request confirmatory testing. If the second test results confirm that remediation is necessary, the trained staff of DEP's radon office will consult with the homeowner. After the work is completed, a postremediation test will be performed. There is no charge for these services.

DONALD F. SMITH & ASSOCIATES Group Health Care Insurance Programs

The past year has seen a great deal of activity within the group health care plans sponsored by the Medical Society of New Jersey. Of primary importance was the major underwriting changes implemented by Blue Cross and Blue Shield of New Jersey in the MSNJ Blue Cross/Blue Shield and major medical programs.

The changes, which affect virtually all of the more than 5,500 participating MSNJ members, became effective April 1, 1988, and include the following:

- Blue Cross/Blue Shield and major medical coverages are offered to new participants only as a single, packaged plan. The coverages are not available separately.
- Persons age 65 and over no longer are eligible to enroll as a new participant for Blue Cross/Blue Shield coverage.
- The Blue Shield Series 500, 750, and 14/20 fixed-fee payment schedules no longer are offered to new

The New Jersey State Department of Health is offering confidential HIV-positive partner notification assistance to all physicians throughout New Jersey. The program, Notification Assistance Program (NAP), originally was announced in March 1988 through a letter to all physicians from Molly Joel Coye, M.D., M.P.H., state commissioner of health. In that announcement, Dr. Coye notified all physicians that trained, professional state health department staff are available to work with physicians and their HIV-positive patients. NAP staff will provide face-to-face counseling to the sexual and needle-sharing partners of HIV patients who are being treated by private physicians. This information is conveyed in a confidential and sensitive manner, without identifying the HIV-positive patient or physician who supplied the identifying information about their partners. Indeed, the notifiers never are the same person who originally obtained the information.

The Department is encouraged by its early efforts,

having successfully contacted 23 clients, all of whom responded favorably to being contacted and notified about being involved with an HIV-positive individual. All those contacts have made appointments at counseling and testing sites to receive indepth pretest counseling. Additional staff have been added since March which allows followup to the partners of HIV clients and also to HIV-positive clients who do not return for their test results. Notification Assistance Program services also are available to frank AIDS cases who are concerned about past or current partners and are unable or unwilling to notify their partners about their possible exposure to HIV.

NAP staff are available to provide indepth presentations about the program and can be contacted at 1-800-367-6543. Any physician wishing to obtain more details about the program or wishing to utilize the services of the Notification Assistance Program also can call 1-800-367-6543.

participants or as an upgrade to current participants.

- All participants must be enrolled for the same contract class (i.e. single or family) under both Blue Cross/Blue Shield and major medical.

- For all employer groups, 75 percent of the eligible employees (or 100 percent if the group has under 10 members) must participate. For dependent coverage to be made available, at least 25 percent of the eligible dependents must be covered.

- For existing employer groups that provide Blue Cross/Blue Shield and major medical, all participating employees must be enrolled for both lines of coverage.

All participating employer groups and individual MSNJ members were advised of the Blues' new underwriting regulations in December 1987. The notice explained the changes in detail and outlined the ramifications of each new provision. In the first week of February, employer groups that were not in compliance with the new consistent enrollment or minimum participation requirements were notified of the options available for bringing their group plan within the new underwriting parameters established by Blue Cross/Blue Shield.

The overall effects of the Blues' new underwriting regulations are expected to produce more stable claims experience and premium rates.

Also, MSNJ introduced a new long-term care insurance program at the beginning of 1988. The program is designed to provide members with valuable insurance protection against the high cost of skilled, intermediate, and custodial nursing care. Despite being available for only a few months, the response to this new MSNJ-sponsored long-term care insurance program has been very positive.

The following presents a summary of the MSNJ-sponsored Blue Cross/Blue Shield, major medical, dental, and long-term care insurance programs and their operations during the past year.

Blue Cross/Blue Shield Program. The MSNJ Blue Cross/Blue Shield program provides coverage to newly enrolled employer groups through the comprehensive Blue Cross contract and the Blue Shield P.A.C.E. payment schedule.

The MSNJ program continues to offer many valuable contractual provisions that are unavailable to members who purchase coverage directly from the Blues. These important advantages include:

- Paid-in-full coverage for stays in nonmember hospitals outside New Jersey.

- Instead of the regular provision for 120 days per benefit year, there are 120 days of hospitalization benefits per admission.

- Coverage for pre-existing conditions at the time of enrollment.

- Rider J 365 coverage for all participants.

- Full hospital benefits for mental conditions, tuberculosis, drug addiction, and contagious diseases which normally are limited to 30 benefit days.

- Coverage for dependent children through the end of the calendar year in which they turn age 23.

- No reduction in benefits when covered members reach age 65.

- Lifelong coverage under the MSNJ group for covered persons and/or their surviving spouses.

The recent claims experience of participants under age 65 has been extremely high. As a result, Blue Cross and Blue Shield of New Jersey requested an average rate increase of 33 percent effective January 1, 1988. After lengthy negotiations, and by using surplus funds from the 1986 coverage year, the MSNJ Committee on Membership Services was able to lower the average increase to 25 percent. Because the actual rate increase varies by program and type of contract, most participants' rates increased slightly more or less than 25 percent.

Premium rates for persons age 65 and over no longer are set by the New Jersey insurance commissioner. Projected costs for all participants now are determined from the combined claims experience of those under age 65 and those age 65 and over. Separate premium rates then are established for each age group according to actuarial studies derived from the Blues' own claims records. These studies found that past premium rates for persons age 65 and over were much too low to cover actual claim costs. The new method of determining premium rates for this age group re-

sulted in a significant rate increase effective January 1, 1988.

There are approximately 5,500 MSNJ members and their employees enrolled under the Blue Cross/Blue Shield program, with the total number of covered persons estimated at more than 14,000.

Major Medical Program. Supplementing the benefits provided by basic Blue Cross/Blue Shield coverage, the MSNJ group major medical insurance program provides unlimited calendar year and lifetime benefits (except for mental care services). The plan also offers participants the choice of a \$200, \$500, or \$1000 calendar year deductible, with a maximum of two deductibles per family in any one year.

The program pays 80 percent of all eligible charges (50 percent for out-of-hospital mental care) and when covered medical expenses reach \$15,000 in a calendar year, the major medical program pays 100 percent of allowable charges for the remainder of that year.

Covered medical services and supplies include physician office visits, prescription drugs, x-rays, diagnostic lab procedures, private duty nursing care, ambulance service, durable medical equipment, and many other expenses.

As evidence of the importance of major medical coverage, benefit utilization under the program has continued to increase. However, to meet the spiralling costs of anticipated claims, the premium rates were increased by an average of 34 percent on January 1, 1988.

At this time, there are approximately 3,000 MSNJ members and their employees, and more than 5,000 covered dependents, enrolled for this excellent major medical insurance protection.

Dental Insurance Program. The MSNJ dental insurance program divides covered dental procedures into four major categories: preventive/diagnostic care, basic care, major care, and orthodontia. There is a \$1,000 per person annual benefit maximum for the first three categories and a separate \$1,000 lifetime maximum for orthodontia services. The \$50 annual deductible is limited to three family members per year.

All benefits are paid on a usual, customary, and reasonable basis in accordance with the following coinsurance schedule:

100%—Preventive/Diagnostic Care, including teeth cleaning, fluoride treatment, x-rays, periodic exams, and other routine services.

80%—Basic Care, including extractions and oral surgical services, fillings, root canal therapy, and inlays.

50%—Major Care, such as crowns, bridges, dentures, and periodontal services.

50%—Orthodontia, including diagnosis, x-rays, installation of appliances, and monthly and retention treatments.

The claims experience under the MSNJ dental program was much better than anticipated for the nine-month period ending December 31, 1986. As a result, a refund of almost 25 percent of premiums was returned to participants.

Despite the favorable claims experience during the 1986 coverage period, program costs in 1988 are projected to rise and a 9 percent premium increase took effect January 1, 1988. This increase follows last year's

12 percent decrease so that participants' costs for dental insurance still is lower than it was two years ago.

The MSNJ dental insurance program currently provides coverage to more than 2,500 member physicians, employees, and dependents.

Long-Term Care Insurance. The long-term care program is the MSNJ's newest sponsored health insurance plan. First introduced in February 1988, this valuable insurance program pays up to \$100 in daily cash benefits for long-term skilled, intermediate, and custodial care in a skilled nursing facility. Also, 50 percent of the daily benefit amount is provided if convalescent care is needed in the patient's home following a qualified skilled nursing facility stay.

Benefits are paid for as long as four years of skilled nursing facility care and two years of convalescent care. All benefit payments are sent directly to the policy holder.

The MSNJ long-term care insurance program is designed so that individual participants can structure the coverage to meet their exact financial needs. Benefits are available in amounts ranging from \$40 to \$100 per day with either a 20-day or 100-day benefit waiting period. Participants also may opt to waive the standard three-day prior hospitalization requirement.

Other advantages include: coverage may be purchased for any person who qualifies; benefits are paid in addition to any other insurance coverage the person may be entitled to; premiums are waived after benefits have been paid for 90 days; and helpful claims representatives eliminate red tape and administrative problems.

The program is made available to all MSNJ members between the ages of 55 and 84. All coverage is contingent upon satisfactory medical history at the time of enrollment.

Conclusion. The MSNJ Committee on Membership Services recognizes that the 1988 Blue Cross/Blue Shield and major medical rate increases are substantial. The increases do, however, reflect the overall utilization of benefits by participating members.

Despite the apparent need for justifiable rate increases, the Committee is pursuing alternatives to the current Blue Cross/Blue Shield and major medical programs. In the coming months, the Committee will review health care insurance programs proposed by commercial insurers that are interested in underwriting the MSNJ group. Other options that are being investigated include self-insurance, alternative funding arrangements, and various cost-containment initiatives.

Participants will be kept advised of all future developments concerning the MSNJ Blue Cross/Blue Shield and major medical programs.

The Committee is pleased with the membership's initial response to the new long-term care insurance plan. Scores of members have called for additional details after receiving the original announcement and brochure. Many members or their spouses and parents already are enjoying the assurance that nursing home costs will not deplete their life savings.

The MSNJ Committee on Membership Services will continue to work toward providing members with attractive health care insurance programs that are efficiently administered and professionally serviced.



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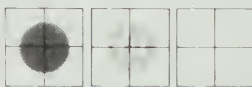
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CLARK MARTIN*

Forced Medicare Bill Prodded; Courtesy Pamphlet Debuts; Auto Insurance Law; Society Fights Malpractice Surcharge; Higher Medicaid Fees; Frivolous Suit Law Enacted

"FORCED MEDICARE" BILL PRODDED

The Assembly sponsor of the mandatory Medicare assignment bill, A-2305, has taken steps to try to snatch the measure out of the Health Committee and place it in position for a floor vote.

Assemblyman Alan J. Karcher (D-Sayreville) has filed notice that at a future Assembly session, he will move to relieve the Committee of the bill. To succeed, the motion would need 41 affirmative votes.

Naturally, the Society is actively working to defeat Karcher's initiative. We are contacting numerous Assemblymen to reconfirm that medicine has sufficient support for its position on this troublesome issue. Assemblyman Karcher, for his part, also is working doggedly to strengthen the bill's prospects. Aided by an organization called United Senior Action (many physicians have seen this group's letters in the newspapers under the signature of its chief spokesman, Al Evanoff), Karcher has persuaded 17 of his Assembly colleagues to add their names to A-2305 as cosponsors.

All of the cosponsors are Democrats, and many are freshmen who were not in office when "forced Medicare" was rejected unanimously by the Health Committee last year. From our discussions with these legislators, the Society has learned that at least some of the Assemblymen were unaware of the political volatility of the issue.

When will Assemblyman Karcher attempt to seize the bill from Committee? It's difficult to say. Parliamentary rules entitle legislators to make such motions at their convenience. Since we can't predict when that will be, the best thing is for all physicians to contact

their Assemblymen now and ask them to oppose Assemblyman Karcher's motion to relieve the Health Committee of A-2305. Remind Assemblymen that the Committee—with the same five members—last year voted the bill down unanimously after hearing hours of testimony.

"COURTESY" PAMPHLET DEBUTS

An attractive new pamphlet announcing the Senior Medical Courtesy Program now is available and has been sent to legislators, county medical societies, offices on aging, and senior citizens' councils.

Unveiled on September 10, 1988, at the Senior Games at Kean College, the pamphlet explains how Senior Medical Courtesy will find a conveniently located physician to treat eligible senior patients at the Medicare assignment rate.

While vocal supporters of the "forced Medicare" bill are busy at work maligning Senior Medical Courtesy, the program is growing rapidly. At this writing, more than 3,500 physicians have volunteered to participate, and some 2,600 patients throughout the state have enrolled. Now that all 120 legislators have received the pamphlet, county societies can expect an increasing number of inquiries about the program.

AUTO INSURANCE LAW

After years of legislative "ping-pong"—bills bouncing back and forth between the Senate and the Assembly—the Legislature and Governor Kean have settled on a new law which makes several changes, including a medical fee schedule, in New Jersey's auto insurance statutes.

The law calls for the Insurance Department to adopt, by next July, a fee schedule to cover medical services for auto accident victims. The schedule will be established on a regional basis, and will be reviewed every other year for adjustments. Balance billing is permitted.

It could have been a lot worse. Medical fee provisions in auto insurance bills which had been approved in one house or the other during the past several months included a maximum \$10,000 coverage; a state-administered "catastrophic" fund for medical expenses over \$75,000; physician DRGs, and a schedule based on Blue Shield rates.

Much negotiation with the Insurance Department lies ahead for the Society to assure that a reasonable schedule is adopted.

SOCIETY FIGHTS MALPRACTICE SURCHARGE

The Society has called on Governor Thomas H. Kean to intervene in the State Insurance Department's plan to impose more than \$60 million in the liabilities of a defunct, cut-rate medical malpractice insurance company on thousands of physicians who had no involvement in the losses.

In a letter to the Governor, Palma E. Formica, M.D., urged him to meet with the Executive Committee "in an open, nonconfrontational forum" to discuss the problem created by the deficit of the New Jersey Medical Malpractice Reinsurance Association.

*Mr. Martin is MSNJ's legislative consultant.

The Association, which was created by the Insurance Department in 1976, sold underpriced malpractice insurance for six years. As a result, it holds an estimated \$22 million in reserves, but anticipates at least \$82 million in claims over the next decade.

Beginning January 1, 1989, the Department wants to impose a 5 percent annual surcharge for seven years on the malpractice premiums of 13,400 physicians and podiatrists in order to eliminate the shortfall.

Under the Department's proposal, physicians who are insured by the Medical Inter-Insurance Exchange of New Jersey (MIENJ) and other carriers, and who paid higher premiums during the time that the Reinsurance Association was in business, would pay the same surcharge as those who purchased the state-sponsored "bargain" insurance. And the Reinsurance Association's 3,500 insured who no longer are practicing in New Jersey would pay no surcharge—even though they may have been responsible for losses.

Dr. Formica's letter asked: "Is it fair to require thousands of responsible physicians who paid dearly for their malpractice insurance during the years when the state offered bargain rates, and who pay even more dearly for their insurance today, to be saddled with the burden of making good the state's debt?"

The Society and MIENJ also are exploring legislative and legal remedies in order to stop the surcharge.

HIGHER MEDICAID FEES

For the first time in 15 years, higher fees are being paid to physicians who care for New Jersey's Medicaid patients. The fee increase—which took effect in August and will be followed by another boost next spring—results from the Society's cooperative efforts with the Department of Human Services and from its work with the Legislature and the Governor's office.

With the new fee schedule, the Society is making progress toward achieving one of its top legislative priorities: a Medicaid program which will foster continuity of treatment for patients who today can receive primary care only in costly hospital outpatient facilities and emergency rooms.

A sampling of the new schedule shows that the fee for a routine visit to a nonspecialist increased from \$7

to \$10 on August 1, and will jump to \$14 next May 1; for a specialist, the \$9 fee went to \$12 in August, and will increase to \$16 next May.

Basic fees for obstetricians increased from \$236 to \$308 this month, and then go to \$468 next April 1. Pediatricians received a single increase for routine newborn care, a \$5 hike to \$27, which took effect on August 1.

While the increase for routine office visits—which will amount to 100 percent by next May—is most gratifying, more must be done for specialists. The Society will continue its work on this issue.

"FRIVOLOUS SUIT" LAW ENACTED

Governor Kean has signed legislation which, when it takes effect in late December, will help persuade attorneys not to "go fishing" by filing law suits which lack merit.

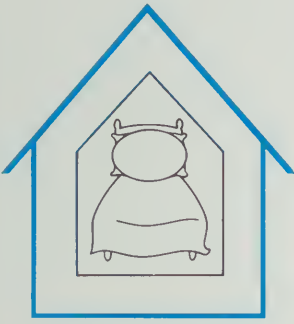
The bill, A-1316/751, was sponsored by Assemblywoman Maureen Ogden (R-Millburn) and Assemblyman Thomas Shusted (R-Westmont). It permits a party who wins in a civil suit to recover attorney fees and litigation costs from the loser, if the judge finds that the legal position of the losing party was frivolous.

Under the new law, Chapter 46 of the Laws of 1988, a judge can label the losing party's suit as frivolous if he finds that:

"(1) The complaint, counterclaim, cross-claim, or defense was commenced, used, or continued in bad faith, solely for the purpose of harassment, delay, or malicious injury; or

(2) The nonprevailing party knew, or should have known, that the complaint, counterclaim, cross-claim, or defense was without any reasonable basis in law or equity and could not be supported by a good faith argument for an extension, modification, or reversal of existing law."

A-1316/751 is the third tort reform measure to be enacted which could help reduce medical malpractice insurance premiums. The other beneficial new laws provide for a "collateral source offset" in monetary judgments (in other words, it stops insurance double-dipping) and lighten the burden of joint and several liability.



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Costs and Claims

Cost Versus Quality; Employer of Injured Worker Can Share in Proceeds of Medical Malpractice Claim

COST VERSUS QUALITY

Troubled by back and leg problems, a woman entered a hospital in Van Nuys, California, for two operations. When her recovery was slower than expected, the patient's physician asked Medi-Cal, California's medical assistance program, which was paying her bill, to grant an eight-day hospital stay extension.

A Medi-Cal nurse at the hospital decided she could not approve the whole extension. She telephoned a Medi-Cal consulting physician who granted only a four-day extension.

Shortly after being discharged, the patient developed clotting and an infection in her leg. Nine days after she was discharged, the patient was hospitalized again and her leg had to be amputated.

She later sued Medi-Cal. At trial, her physician testified that if his patient had not been discharged earlier than recommended, the problems would have been corrected in time to save her leg.

A jury awarded the patient \$500,000. A California court of appeals decision reversed the judgment, finding that the medical decision to discharge her met the applicable standard of care. The court also noted that the treating physicians did not try to appeal the early discharge decision.

That 1986 case was important because it was the first judicial consideration of the tradeoff between the cost-containment process of "utilization review" and medical malpractice liability, according to Barry Furrow, a Delaware Law School professor who spoke at an ABA Medical Malpractice National Institute in Reno in March.

Although Medi-Cal was not liable, the decision warns physicians and third-party payors of health care that they can be held legally accountable. The California court stated: "The patient who requires treatment and who is harmed when care which should have been provided is not provided should recover for injuries suffered from all those responsible for the deprivation of such care including, when appropriate, health care payors."

The court concluded that "While we recognize, realistically, that cost consciousness has become a permanent feature of the health care system, it is essential that cost limitation programs not be permitted to corrupt medical judgment."

If a physician, against his better judgment, discharges a patient when reimbursement is denied, he risks liability for malpractice, said the professor. So does the utilization-review body that negligently reviews the patient's record.

"It reveals judicial hostility to the argument that cost constraints should get a physician off the hook for patient injury, or that sloppy utilization review is tolerable," said the professor.

He said as pressures continue to mount to control medical costs, more cases will pit quality of care against cost containment.

Michael D. Roth, a Los Angeles attorney who represents health care providers nationally, agrees. "If health care providers are not careful, I think you will see more than a rash of these suits," he said.

In a case similar to the one aforementioned, Blue Cross is a defendant in a \$10 million suit pending in Los Angeles superior court, according to Roth. He said the suit alleges that the premature discharge of a patient undergoing chemical detoxification resulted in the patient dying of an overdose three weeks later.

Given the potential liability in these cases, Roth suggests that lawyers advising utilization-review programs ensure the programs take steps to reduce their exposure. He provides the following basic checklist:

- Nurse reviewers should be licensed and have received utilization-review training.
- Physician reviewers should be specialists in the patient's medical care area.
- Before issuing a denial, physician reviewers should thoroughly discuss the case with the attending physician, preferably review the patient's records, and if feasible, examine the patient.
- If a denial is issued, the patient or physician must be allowed to appeal the decision to a panel of physicians for further review.
- Before implementing or agreeing to comply with medical criteria to be used in evaluating admissions

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are Director of the Department and Director of Special Projects.

and length of stay, allow enough time to evaluate their appropriateness.

- Hospitals should establish mechanisms to monitor and supervise utilization-review programs on their premises.

Addendum. The 1988 House of Delegates of the Medical Society of New Jersey recommended that third-party payor peer review activities be held accountable to the same standards as are plenary licensed physicians.

The following is a response from Frank J. Malta, M.D., president of the New Jersey State Board of Medical Examiners (May 26, 1988):

The New Jersey Board of Medical Examiners has taken the position that peer review activity which encompasses all of the components of decision making into the appropriateness of patient care requires a current plenary license. Therefore, peer review activity involves the practice of medicine. It would not be appropriate for third-party payors to deny care based on cost consideration alone. Rather, care should be rendered based on the necessity of care in accordance with acceptable standard of practice. Therefore, the Board's position is that the final determination for the appropriateness of care is a physician and not a non-physician reviewer.

This Board has articulated that position in the past, noting that medical experts and those participating in peer review activities who fail to meet the standard of acceptable practice could be found guilty of professional misconduct, and thereby subject to disciplinary action under the Medical Practice Art.

This Board has the responsibility by mandate of the Legislature to protect the health, safety, and welfare of the public. It is charged with the responsibility of investigating complaints from all arenas. It is apparent that concerns expressed by the Medical Society's House of Delegates was prompted by improper conduct by third-party payors or independent reviewers. The Board recommends that letters of complaint be filed with the Board for appropriate and expeditious investigation.

(Paul Marcotte, *American Bar Association Journal*, June 1, 1988).

EMPLOYER OF INJURED WORKER CAN SHARE IN PROCEEDS OF MEDICAL MALPRACTICE CLAIM

A statute precluding an employer's independent action against physicians, chiropractors, and podiatrists whose negligence aggravated an employee's work-related injuries was unconstitutional, a Wisconsin appellate court ruled. An employee became a quadriplegic as a result of negligent treatment for a work-related injury. He was permanently and totally disabled.

The employee settled his malpractice claim against the treating physician. His employer then sought subrogation rights in the settlement because it was obligated to pay workers' compensation for the injury as enhanced by the negligence. The trial court found that the applicable statute precluded an independent action against the treating physician. However, the court found that the statute violated the equal protection of the laws and was unconstitutional.

The employee appealed the judgment finding the statute unconstitutional. The court said that an employer generally had the right to maintain an action against and share in the recovery from any party who also was liable for an employee's work-related injury. The effect of the statute was to deny subrogation to a limited class of employers—those whose employee injuries were aggravated by the negligence of physicians, chiropractors, or podiatrists. All other employers whose employees' injuries were aggravated by a third party could recover under the statute.

The court said that if the statute had been applied to a malpractice claim against any health care provider, there would be a rational basis for the classification. However, the statute was limited to claims against physicians, chiropractors, and podiatrists. Finding that the limited application of the statute denied certain employers equal protection of the law because it was arbitrary and not rationally related to a legitimate state interest, the court affirmed the lower court's judgment. (Reprinted from *THE CITATION* with permission, American Medical Association, 535 N. Dearborn Street, Chicago IL 60610, April 1, 1988, Volume 56, No. 12)

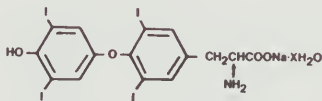
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LEVOXINE (L-thyroxine) tablets taken orally provide T_4 which upon absorption can not be distinguished from T_4 that is secreted endogenously.

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CONTRAINDICATIONS:

L-thyroxine therapy is contraindicated in thyrotoxicosis, acute myocardial infarction and uncorrected adrenal insufficiency.

WARNINGS:

Drugs with thyroid hormone activity, alone or together with other therapeutic agents, have been used for the treatment of obesity. In euthyroid patients, doses within the range of daily hormonal requirements are ineffective for weight reduction. Larger doses may produce serious or even life-threatening manifestations of toxicity, particularly when given in association with sympathomimetic amines such as those used for their anorectic effects.

PRECAUTIONS:

General — Caution must be exercised in the administration of this drug to patients with cardiovascular disease. Development of chest pains or other aggravation of the cardiovascular disease requires a reduction of dosage.

LEVOXINE (L-thyroxine) 100 mcg (0.1 mg), 200 mcg (0.2 mg) and 300 mcg (0.3 mg) tablets contain FD & C Yellow No. 5 (tartrazine) which may cause allergic-type reactions (including bronchial asthma) in certain susceptible individuals. Although the overall incidence of FD & C Yellow No. 5 (tartrazine) sensitivity in the general population is low, it is frequently seen in patients who also have aspirin hypersensitivity.

Information For The Patient — Patients on thyroid preparations and parents of children on thyroid therapy should be informed that:

1. Replacement therapy is to be taken essentially for life, with the exception of cases of transient hypothyroidism, usually associated with thyroiditis, and in those patients receiving a therapeutic trial of the drug.
2. They should immediately report during the course of therapy any signs or symptoms of thyroid hormone toxicity, e.g., chest pain, increased pulse rate, palpitations, excessive sweating, heat intolerance, nervousness, or any other unusual event.
3. In case of concomitant diabetes mellitus, the daily dosage of antidiabetic medication may need readjustment as thyroid hormone replacement is achieved. If thyroid medication is stopped, a downward readjustment of the dosage of insulin or oral hypoglycemic agent may be necessary to avoid hypoglycemia. At all times, close monitoring of urinary glucose levels is mandatory in such patients.

4. In case of concomitant oral anticoagulant therapy, the prothrombin time should be measured frequently to determine if the dosage of oral anticoagulants is to be readjusted.

5. Partial loss of hair may be experienced by children in the first few months of thyroid therapy, but this is usually a transient phenomenon and later recovery is usually the rule.

Laboratory Tests — The patient's response to thyroid replacement may be followed by laboratory tests such as serum thyroxine (T_4), serum triiodothyronine (T_3), free thyroxine index and thyroid stimulating hormone (TSH) blood levels.

Drug Interactions — In patients with diabetes mellitus, addition of thyroid hormone therapy may cause an increase in the required dosage of insulin or oral hypoglycemic agents. Therefore, patients with diabetes mellitus should be observed closely for possible changes in antidiabetic drug dosage requirements.

Patients stabilized on oral anticoagulants who are found to require thyroid replacement therapy should be watched very closely when therapy is started. If a patient is truly hypothyroid, it is likely that a reduction in anticoagulant dosage will be required. No special precautions appear to be necessary when oral anticoagulant therapy is begun in a patient already stabilized on maintenance thyroid replacement therapy.

Cholestyramine binds both T_4 and T_3 in the intestine, thus impairing absorption of these thyroid hormones. In vitro studies indicate that the binding is not easily removed. Therefore, four to five hours should elapse between administration of cholestyramine and thyroid hormones.

Estrogens tend to increase serum thyroxine-binding globulin (TBG). In a patient with a non-functioning thyroid gland who is receiving thyroid replacement therapy, free thyroxine may be decreased when estrogens are started thus increasing thyroid requirements. However, if the patient's thyroid gland has sufficient function the decreased free thyroxine will result in a compensatory increase in thyroxine output by the thyroid. Therefore, patients without a functioning thyroid gland who are on thyroid replacement therapy may need to increase their thyroid dose if estrogens or estrogen containing oral contraceptives are given.

Drug/Laboratory Test Interactions — The following drugs or moieties are known to interfere with laboratory tests performed on patients taking thyroid hormone: androgens, corticosteroids, estrogens, oral contraceptives containing estrogens, iodine-containing preparations, and the numerous preparations containing salicylates.

1. Changes in TBG concentration should be taken into consideration in the interpretation of T_4 and T_3 values. In such cases, the unbound (free) hormone should be measured. Pregnancy, estrogens, and estrogen-containing oral contraceptives increase TBG concentrations. TBG may also be increased during infectious hepatitis. Decreases in TBG concentrations are observed in nephrosis, acromegaly, and after androgen or corticosteroid therapy. Familial hyper- or hypo-thyroxine-binding-globulinemias have been described. The incidence of TBG deficiency approximates 1 in 9000. The binding of thyroxine by thyroid-binding prealbumin (TBPA) is inhibited by salicylates.

2. Medical or dietary iodine interferes with all in vivo tests of radio-iodine uptake, producing low uptakes which may not be reflective of a true decrease in hormone synthesis.

3. The persistence of clinical and laboratory evidence of hypothyroidism in spite of adequate dosage replacement indicates either poor patient compliance, poor absorption, excessive fecal loss, or inactivity of the preparation. Intracellular resistance to thyroid hormone is quite rare.

Carcinogenesis, Mutagenesis, And Impairment Of Fertility

— A reportedly apparent association between prolonged thyroid therapy and breast cancer has not been confirmed and patients on thyroid for established indications should not discontinue therapy. No confirmatory long-term studies in animals have been performed to evaluate carcinogenic potential, mutagenicity or impairment of fertility in either males or females.

Pregnancy — Category A — Thyroid hormones do not readily cross the placental barrier. The clinical experience to date does not indicate any adverse effect on fetuses when thyroid hormones are administered to pregnant women. On the basis of current knowledge, thyroid replacement therapy to hypothyroid women should not be discontinued during pregnancy.

Nursing Mothers — Minimal amounts of thyroid hormones are excreted in human milk. Thyroid is not associated with serious adverse reactions and does not have a known tumorigenic potential. However, caution should be exercised when thyroid is administered to a nursing woman.

Pediatric Use — Pregnant mothers provide little or no thyroid hormone to the fetus. The incidence of congenital hypothyroidism is relatively high (1:4,000) and the hypothyroid fetus would not derive any benefit from the small amounts of hormone crossing the placental barrier. Routine determinations of serum (T_4) and/or TSH is strongly advised in neonates in view of the deleterious effects of thyroid deficiency on growth and development.

Treatment should be initiated immediately upon diagnosis and maintained for life, unless transient hypothyroidism is suspected; in which case, therapy may be interrupted for 2 to 8 weeks after the age of 3 years to reassess the condition. Cessation of therapy is justified in patients who have maintained a normal TSH during those 2 to 8 weeks.

ADVERSE REACTIONS:

Adverse reactions are due to overdosage and are those of induced hyperthyroidism.

OVERDOSAGE — Excessive dosage of thyroid medication may result in symptoms of hyperthyroidism. Since, however, the effects do not appear at once, the symptoms may not appear for one to three weeks after the dosage regimen is begun. The most common signs and symptoms of overdosage are weight loss, palpitation, nervousness, diarrhea or abdominal cramps, sweating, tachycardia, cardiac arrhythmias, angina pectoris, tremor, headache, insomnia, intolerance to heat and fever. If symptoms of overdosage appear, discontinue medication for several days and reinstitute treatment at a lower dosage level.

Laboratory tests such as serum T_4 , serum T_3 and the free thyroxine index will be elevated during the period of overdosage.

Complications as a result of the induced hypermetabolic state may include cardiac failure and death due to arrhythmia or failure.

TREATMENT OF OVERDOSAGE — Dosage should be reduced or therapy temporarily discontinued if signs and symptoms of overdosage appear. Treatment may be reinstituted at a lower dosage. In normal individuals, normal hypothalamic-pituitary-thyroid axis function is restored in 6 to 8 weeks after thyroid suppression.

Treatment of acute massive thyroid hormone overdosage aimed at reducing gastrointestinal absorption of the drugs and counteracting central and peripheral effects, mainly those increased sympathetic activity. Vomiting may be induced initially if further gastrointestinal absorption can reasonably be prevented and barring contraindications such as coma, convulsions, a loss of the gagging reflex. Treatment is symptomatic and supportive. Oxygen may be administered and ventilation maintained. Cardiac glycosides may be indicated if congestive heart failure develops. Measures to control fever, hypoglycemia, or fluid loss should be instituted if needed. Antiadrenergic agents, particularly propranolol, have been used advantageously in the treatment of increased sympathetic activity. Propranolol may be administered intravenously at a dosage of 1 to 3 mg over a 10 minute period orally, 80 to 160 mg/day, especially when no contraindications exist for its use.

DOSAGE AND ADMINISTRATION:

The goal of therapy should be the restoration of euthyroidism as judged by clinical response and confirmed by appropriate laboratory tests such as serum thyroxine (T_4), serum triiodothyronine (T_3), free thyroxine index and thyroid stimulating hormone (TSH) blood levels. The age and general condition of the patient and the severity and duration of hypothyroid symptoms determine the starting dosage and the rate of incremental dosage increase leading to a final maintenance dosage.

In otherwise healthy adults, the recommended initial dose is 25 to 100 mcg (0.025 to 0.1 mg) daily, while the predicted maintenance dose of 100 to 200 mcg (0.1 to 0.2 mg) daily may be achieved in two to three weeks.

In the elderly patient with long standing disease, evidence of myxedema, or evidence of cardiovascular dysfunction, the initial dose may be as little as 12½ mcg (0.0125 mg) per day. Incremental increases of 25 mcg (0.025 mg) per day at 3 to 4 week intervals may be instituted depending on patient response. It is the physician's judgement of the severity of the disease and close observation of patient response which determine the rate and extent of dosage increase.

In infants and children there is a great urgency to achieve thyroid replacement because of the critical importance of thyroid hormone in sustaining growth and maturation. Despite smaller body size, the dosage needed to sustain a full rate of growth, development and general thriving is higher in the child than in the adult. The recommended daily replacement dosage of L-thyroxine in childhood is: 0-1 years: 9 mcg/kg; 1-5 years: 6 mcg/kg; 6-10 years: 4 mcg/kg; 11-20 years: 3 mcg/kg daily.

DOSAGE FORMS AVAILABLE:

LEVOXINE (L-thyroxine) tablets are supplied as oval, coded, potency marked tablets in 10 strengths, 12½ mcg (0.0125 mg) — maroon, 25 mcg (0.025 mg) — orange, 50 mcg (0.05 mg) — white, 75 mcg (0.075 mg) — purple, 100 mcg (0.1 mg) — yellow, 125 mcg (0.125 mg) — brown, 150 mcg (0.15 mg) — blue, 175 mcg (0.175 mg) — turquoise, 200 mcg (0.2 mg) — pink and 300 mcg (0.3 mg) — green in bottles of 100 and 1000, and unit dose in cartons of 10 (10 strips of 10 tablets).

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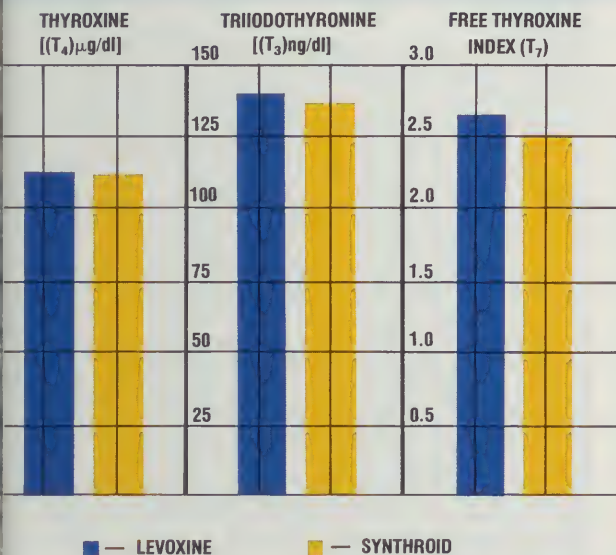
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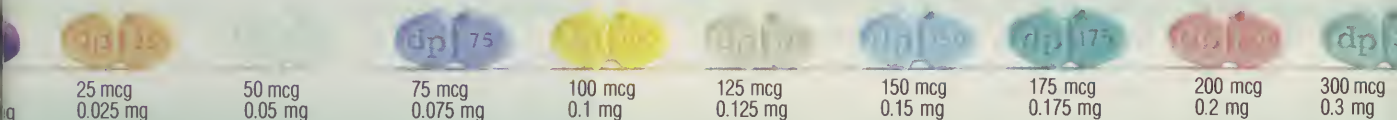
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*Governor Thomas H. Kean (right) signs bill
law as New Jersey State Medical Underwriter
Inc. President Peter Sweetland (left) and
Chairman Henry J. Mineur, M.D. (center) look*

Election 1988

PALMA E. FORMICA, M.D.*

The din and the cacophony of the presidential conventions have settled and we need to turn our attention to the reality of the political scene. As a state medical society, we cannot endorse a particular party or person. Yet, we encourage our members to become involved.

Some have said that it does not matter who is elected president because Congress makes the laws. However, the head of state sets the direction of the nation. We must be concerned with those elected.

Most physicians shy away from political involvement saying they are too busy. Yet, we protest vigorously and vociferously about the intrusion of government into the very practice of medicine. As citizens and physicians, we must become involved if this nation is to remain free.

If party activity is not the way, we can support those who are our friends through private donations or

through the political action committees. We all are aware of AMPAC and JEMPAC, yet only 11 percent of New Jersey physicians participate.

If you personally know a legislator, locally or nationally, you can be the contact person—the key-man—with that individual. Politicians and their families have personal physicians. No other group is shy about contacting representatives.

When a bill needs action, write or call lawmakers. Legislative aides frequently have said that the medical profession does a lot of complaining but very little communicating on issues that are of importance to them. It is easier to change a section of a bill than to have a law repealed.

We do learn some lessons! When the optometrist prescribing bill was introduced, very few grassroots citizens—especially physicians—took the time to write or call their legislators. But, your assemblyman, congressman, or senator need to hear from each of us. The matter was changed when the tort reform bills were in the senate committee and the members of the society were asked to call and write the committee members. Individual senators were deluged with mail and they got the message; the bill was released from committee. We should learn that in politics, as in life, consistency and persistence are the keys.

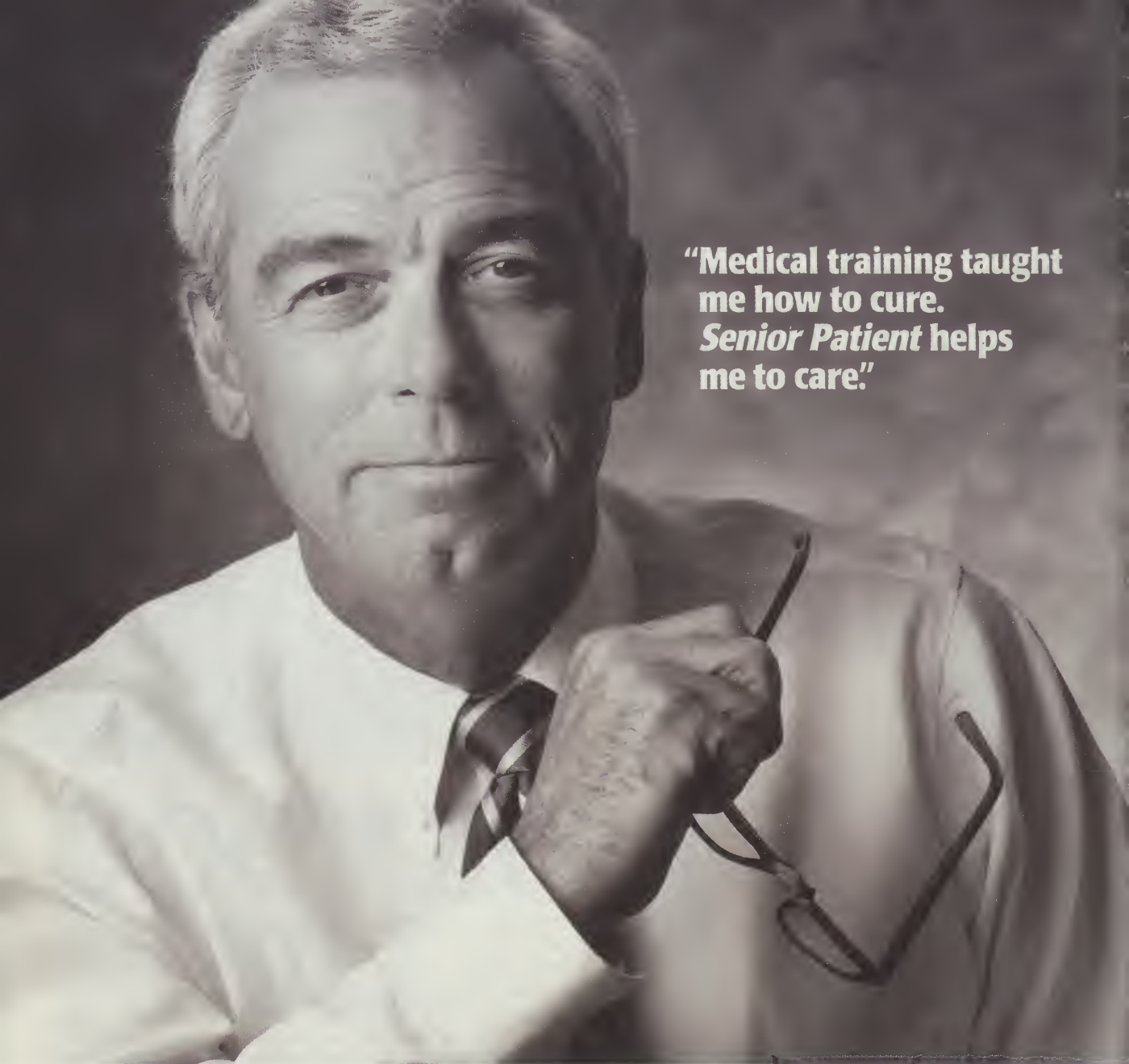
If we are too busy to call or write, or be involved, have your spouse, children, or office staff speak in our names—or write the letter we sign.

Throughout the state, nurses have sent me hundreds of letters protesting the registered care technicians. The majority were not only form letters but were duplicated and then signed. Most legislative offices are more concerned with the amount of mail for or against an issue than the content of the letter.

These are just a few of the ways we can and must become involved in the political process. Many county medical societies are sponsoring meetings with legislators and aspirants. I urge you to attend these meetings. Make your voice heard. Stop in to see your assemblyman, congressman, and state and national senators. Get to know them and their legislative aides.

Most of all, each of us has the obligation and responsibility of voting on November 8. Democracy will succeed only if we respect and use our right to vote.

*Correspondence may be addressed to Dr. Palma Formica, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648.



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Dr. George L. Triebenbacher

PALMA E. FORMICA, M.D.

On a sunny day, August 24, 1988, George L. Triebenbacher, M.D., represented the Medical Society of New Jersey at a political meeting. Jocular, enthusiastic, and committed, he exuded the confidence of a man in his prime, who "never felt better." Within a few

hours, his life was unexpectedly truncated by a fatal dysrhythmia while driving home from the meeting.

As physicians, death is a regular part of our lives. It is the reality of the ultimate victor. Death is part of being a doctor. Then comes a time when we are affected personally through the death of a loved one—spouse, relative, or friend. The disbelief, the pain, and the sorrow affects us all. We are vulnerable. We, the healers, are not spared.

How does one sum up the gifts of George Triebenbacher's life?

His devotion to his beloved wife, Theresa, and his love for his children, Peter, John, George, and Pauline, are well known.

Theirs is the greatest loss.

After graduating from the State University of New York Downstate Medical Center in 1955, he served in the Air Force until 1958. He wore many hats: chief of the Outpatient Department; chief of surgery, assistant chief of obstetrics and gynecology, and chief of the nursery. This prepared him well for setting up family practice in Beach Haven. He was so proud of his Island Medical Center. Since 1958, George served his patients on Long Beach Island in an exemplary manner—always physician, counselor, and friend. And, to that island community he brought a bit of Hawaii in his untraditional garb of bright, flowered shirts.

Dr. Triebenbacher was a member of the Long Beach Board of Health since 1984 and of the Ocean County Department of Health since 1975, and was Assistant County Medical Examiner. School physician, bank director (Bay State Bank), national aviation medical examiner, and United States Coast Guard national physician were among his civic titles. George was a communicant of St. Francis Parish in Brant Beach, a



The 1988-1989 Board of Trustees of the Medical Society of New Jersey, at the Annual Meeting. Dr. Triebenbacher is standing, second from the left.

member Third Degree of the Knights of Columbus, and a member of the board of directors of the St. Francis Center, in Brant Beach.

One of his main loves was his profession. George was proud to be a family physician. He was a diplomate of the American Board of Family Practice, a fellow of the American Academy of Family Physicians, a past-president of the New Jersey Academy of Family Physicians, and an alternate delegate to the national body. He was a national board member of the Family Health Foundation of America and was instrumental in establishing the New Jersey division of that organization.

Continuing education found a champion in George Triebenbacher. As clinical assistant professor of the UMDNJ-Robert Wood Johnson Medical School, he served in the Department of Family Medicine; he was a role model and mentor for medical students.

His educational involvement made him an active part of the Academy of Medicine of New Jersey. He served as secretary and was second vice-president at the time of his death.

In the Ocean County Medical Society, George Triebenbacher was an outstanding leader, having held the various chairs of office and was on its Board of Trustees. The natural progression was to be elected to the Board of the Medical Society of New Jersey and to the American Medical Association House of Delegates.

Not only medical politics, but legislative activities in general intrigued him. He loved a "good fight." Secretary to the JEMPAC board put him into the decision-making arena.

In the 58 years of his life, George Lewis Triebenbacher touched many people. He has been called the consummate volunteer, performing each task with the touch of excellence. A man of vision and action, George has gifted us all with his life.



Dr. George Triebenbacher

No one can replace him. He is and will be missed by those of us who depended on his wisdom, advice, and charm. How fortunate we are to have known him and to have shared his life!

May he enjoy eternal peace!

Why Wait?



In the depressed and anxious patient

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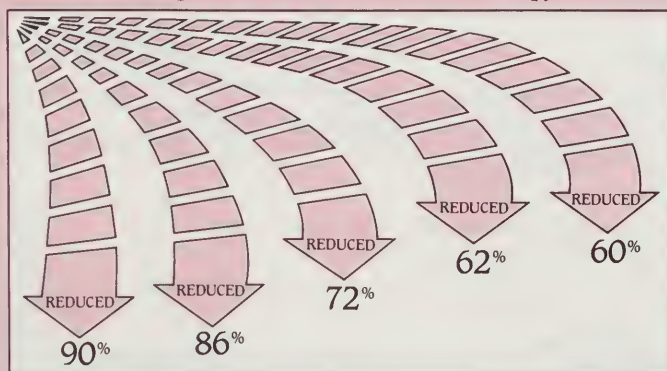


In The First Week¹...

And The Weeks That Follow

- ➔ 74% of patients experienced improved sleep after the first *h.s.* dose¹
- ➔ First-week reduction in somatic symptoms¹

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*Patients often presented with more than one somatic symptom.

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Limbitrol DS[®]

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) ^(N)

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Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

Please see references and summary of product information on following page.

In moderate depression and anxiety

- ➡ 74% of patients experienced improved sleep after the first *h.s.* dose¹
- ➡ First-week improvement in somatic symptoms¹
- ➡ 50% greater improvement with Limbitrol in the first week than with amitriptyline alone²

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Limbitrol® DS

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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner VP, et al: *Psychopharmacology* 61:217-225, Mar 22, 1979.

Limbitrol® (N) Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Use in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: **Cardiovascular:** Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. **Psychiatric:** Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. **Neurologic:** Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. **Anticholinergic:** Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. **Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. **Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. **Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. **Endocrine:** Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. **Other:** Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

How Supplied: Double strength (DS) Tablets, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and Tablets, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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PROTEIN DEFICIENCY IN THREE GENERATIONS OF ONE FAMILY

N. PETER ZAUBER, M.D., AND ALEXANDER B. KUDRYK, M.D., LIVINGSTON*

Six members from one family were found to have low levels of protein C. Affected individuals spanned three generations. In this family, age appeared to be a major determinant for the development of symptoms.

Clotting is a complex protein system, resulting in a fibrin meshwork, which can be initiated and maintained by numerous stimuli. Regulating influences, therefore, are necessary to avoid uncontrolled and excessive clotting. Protein C, a vitamin K-dependent plasma protein that functions as a circulating anticoagulant, is one such regulator. In its active form, protein C inhibits activated factors V and VIII.^{1,2} Additionally, protein C may facilitate fibrinolysis by neutralizing a plasma inhibitor of tissue plasminogen activator, thereby facilitating the fibrinolytic action of plasmin (Figure 1).³ Two other recognized regulators are protein S, a cofactor for protein C, and anti-thrombin III, which inactivates thrombin and, to a lesser extent, several other clotting factors.

Clinical evidence for protein C involvement in the regulation of coagulation comes from the observation that blood levels of protein C reduced to just one-half of normal increase the risk of clinically significant thrombosis. Transmission of hereditary protein C deficiency appears to be autosomal dominant in the few families studied. Family members affected as heterozygotes typically present with thrombotic disease in their second to fourth decades. We report six members of one family, from three generations, with low protein C levels.

PATIENTS AND METHODS

Family Report. The proband (III-2 in Figure 2) is a 50-year-old male born in Cuba of Greek and Spanish lineage who developed thrombosis of his left femoral artery following a myelogram at age 44 years. He responded well to warfarin (Coumadin®) anticoagulation. At age 45 years, a cholecystectomy was complicated by right leg phlebitis and a pulmonary embolus. However, this time warfarin administration resulted in "coumarin necrosis" of numerous soft tissue sites. The diagnosis of protein C deficiency was established three years later during evaluation for claudication. Warfarin anticoagulation was initiated successfully and has been maintained continuously.⁴

The proband's paternal grandmother (I-1 in Figure 2) died at the age of 98 years and was said to have suffered from bouts of phlebitis. The proband's father, who is 74 years old (II-2 in Figure 2), and his aunt, who is 71 years old (II-6 in Figure 2), have experienced recurrent deep venous thromboses and pulmonary emboli during the last 10 years. They cur-

*From the Department of Medicine, Saint Barnabas Medical Center, Livingston, where Dr. Zauber is attending and Dr. Kudryk is a medical resident. Dr. Zauber also is a clinical instructor, Division of Hematology-Oncology, East Orange Veterans' Hospital. Correspondence may be addressed to Dr. Zauber, 22 Old Short Hills Road, Livingston, NJ 07039.

TABLE
Protein C Levels and Clinical Findings in Family Members

Pedigree Position	Age When Tested	Sex	Protein C Antigen Level (%)	Clinical Thrombosis
I-1	—	F	—	+
II-2	73	M	32	+
II-3	74	F	98	-
II-5	74	F	90	-
II-6	70	F	35	+
III-1	52	M	76	-
III-2*	48	M	45	+
III-3	44	F	104	-
III-4	42	F	87	-
III-5	39	F	25	-
IV-1	21	F	20	-
IV-2	21	M	34	-
IV-3	24	F	84	-
IV-4	28	M	87	-
IV-5	30	M	90	-

*Propositus

rently are receiving oral anticoagulation. The propositus' first cousin (III-5 in Figure 2), 39 years old, and his fraternal twin children (IV-1,2 in Figure 2), aged 21 years, have not yet had problems with thrombotic disease.

Protein C Measurements. Plasma samples were obtained from the propositus and from an additional 13 members of his family when they were not taking oral anticoagulants. Venous blood was drawn into 3.8 percent sodium citrate and 0.1 mol/L epsilon aminocaproic acid, 1 part anticoagulant to 9 parts blood. Plasma was separated immediately and stored at -70°C. Protein C was measured by electroimmunoassay using a goat antihuman protein C obtained from American Diagnostics in Greenwich, Connecticut. Assays were performed in the laboratory of Dr. M. Karpatkin, in New York. The levels were expressed as a percentage of pooled normal adult plasma corrected for anticoagulant dilution.⁵ All assays with protein C antigen levels less than 50 percent of control were repeated for verification.

RESULTS

Eight of the 14 family members tested had normal protein C antigen levels ranging between 76 percent and 104 percent and no history of increased throm-

botic tendency. The remaining 6 family members had protein C antigen levels between 20 percent and 45 percent. The propositus' level was 45 percent. His father's level was 32 percent and his aunt's level was 35 percent. The levels of the younger, asymptomatic members were: 25 percent in the propositus' cousin, and 20 percent and 34 percent in his affected twin children (Table).

DISCUSSION

Our data confirm earlier results that reduction of protein C levels to less than one half of normal is associated with a high risk of venous thrombosis, and is on an inherited basis.⁶

The overall prevalence of heterozygous protein C deficiency in nonselected populations has been reported as high as 1 person in 200 to 300 persons.⁷ Yet, these authors claim that the incidence of thromboembolic events associated with protein C deficiency is low. This discrepancy may result from unidentified heterozygotes as well as from the later age of onset of thrombotic problems in some deficient patients.

Protein C deficiency may present clinically as one or more of a variety of conditions, including superficial phlebitis, deep venous thrombosis, arterial thrombosis, pulmonary embolism, and cerebrovascular acci-

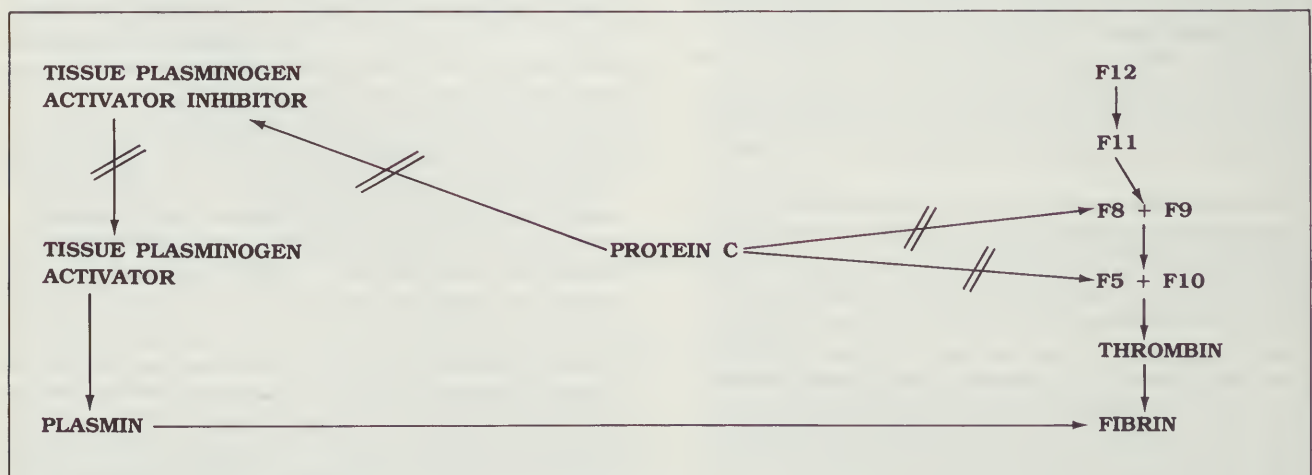


Figure 1—Role of protein C in coagulation; activation —→; inhibition —//→.

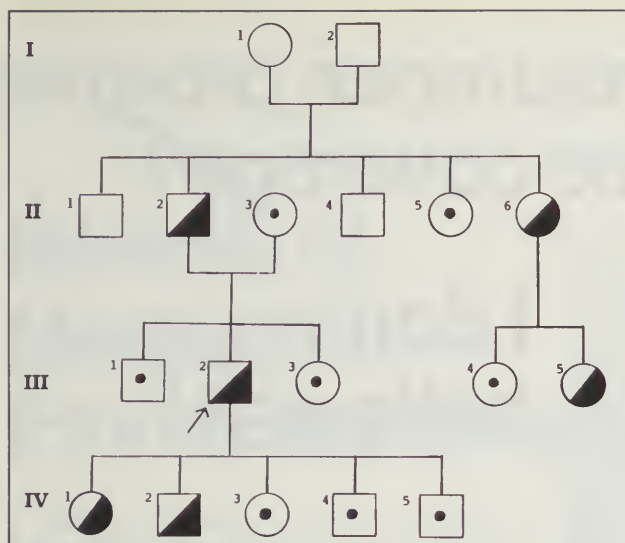


Figure 2—Pedigree of family with protein C deficiency. → denotes the proband, squares represent males, circles represent females, empty symbols represent individuals not studied, symbols with dots represent individuals with normal protein C levels, and blackened symbols are heterozygote deficiencies.

dent.^{8,9} A unique presentation of protein C deficiency is "warfarin skin necrosis" in which local thrombosis of venules occurs secondary to a further decrease in fibrinolysis during initiation of warfarin therapy.¹⁰

Age appeared to be a more important determinant for the development of symptoms than the actual protein C level for our study family. The affected individuals under the age of 40 years at the time of study had been totally asymptomatic, despite having lower levels of protein C than the symptomatic, older individuals.

Several family studies have revealed the mean age of onset of thrombosis to be less than 30 years.^{6,11,12,13} However, other studies reported three families with 13 protein C deficient individuals in whom the mean age of onset of thrombotic problems was 48 years.^{7,14} As with our proband, tissue injury may be a particularly important trigger factor for the development of thrombosis.

Our tests revealed 6 affected individuals out of 14 individuals studied. If, by history, individual I-1 is considered deficient and if individuals II-1 and II-4 are considered normal, then there are 7 affected individuals out of a possible 17, or 41 percent. This is close to the 50 percent incidence expected with an autosomal dominant inheritance pattern. Similar percentages have been reported by others.^{11,12}

Our data reveal an equal sex ratio, with three males and three females having low levels of protein C. Others also have reported an equal sex distribution. Of 96 patients with protein C deficiency identified by sex in 31 families, the male:female ratio was 1.1:1.^{6,7,11,13,14}

A deficiency of one of the regulatory proteins of clotting, protein C, protein S, or anti-thrombin III, should be considered in any patient experiencing a significant

or unprovoked major thrombosis. Similar thought should be given to any young patient with even a minor thrombosis. In particular, protein C deficiency should be considered in any patient experiencing warfarin necrosis.

We believe the development of a first thrombosis in protein C deficient patients is justification for the initiation of life-long oral anticoagulation. Identification of symptomatic protein C deficient patients and use of anticoagulation should reduce their subsequent morbidity and mortality from thrombotic disease. It also will allow for screening of family members and for genetic counseling.

There are no clear guidelines for anticoagulation of asymptomatic heterozygotes. We do not recommend such therapy until the first thrombotic event, to avoid potential toxicity associated with years of unnecessary anticoagulation. However, this approach must be balanced against the morbidity and possible mortality of a major thrombosis.

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HYPERPARATHYROIDISM MASQUERADING AS HYPEREMESIS GRAVIDARUM

DANIEL C. BUDD, M.D., MARIA MARTA E. KUMKA, M.D., ABHAY K. SUDA, M.D.,
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Vomiting is a forgotten manifestation of primary hyperparathyroidism. During pregnancy, this condition clinically can be indistinguishable from hyperemesis gravidarum and should be considered in patients where the vomiting atypically persists past the first trimester.

During pregnancy, diseases associated with pernicious vomiting as the primary symptom may be difficult to distinguish from hyperemesis gravidarum. A patient who had intractable hyperemesis gravidarum was found to have hypercalcemia, suggesting primary hyperparathyroidism as the true underlying cause of her vomiting. Because hyperparathyroidism during pregnancy is associated with significant risk of fetal loss and neonatal and maternal morbidity, its recognition is critical.

CASE REPORT

A 34-year-old Hispanic woman, gravida 1, para 0-0-0, at 11 weeks' gestation was admitted for severe nausea and vomiting for 36 hours prior to admission. She was unable to hold down liquids and complained of extreme tiredness and lethargy. She stood five feet tall and weighed 98 pounds (normal weight, 100 pounds); she lost 3 pounds since her prenatal office visit two weeks earlier. Appearing sick, weak, and dehydrated, the patient was admitted for intravenous hydration and nutritional assessment. Laboratory studies revealed: Hgb 12.9 g/dl, Hct 38.1 percent, sodium 135 meq/l, potassium 2.9 meq/l, chloride 107 meq/l, bicarbonate 26.5 meq/l, calcium 14.3 mg percent (8.5-10.2 mg percent), and phosphorus 1.4 mg percent (2.3-4.7 mg percent). These values represented the first

chemistries drawn since the patient became pregnant. A sonogram to exclude a hydatidiform molar pregnancy confirmed a single intrauterine fetus of 11.1 weeks' gestation. She responded promptly to hydration, antiemetics, and bedrest; she was discharged after six days without further evaluation of her hypercalcemia.

She was readmitted one week later with severe nausea and vomiting, dehydration, and a three-pound weight loss. The previous therapeutic management was instituted, but she continued to vomit and lose weight. Further studies revealed: serum calcium 15.9 mg percent, urine calcium 581 mg/24 hours (50 to 150 mg/24 hours), C-terminal parathyroid hormone 1.9 ng/ml (less than 0.6 ng/ml), 25-hydroxy vitamin D 33 ng/ml (15 to 60 ng/ml), and magnesium 1.4 mg/dl (1.8 to 2.4 mg/dl). Thyroid, gastrin, and cortisol assays were normal. Intravenous hyperalimentation was begun; magnesium was added to the solution after calcium levels were normalized.

A diagnosis of primary hyperparathyroidism was made. Saline diuresis with furosemide was instituted,

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lowering the calcium to 10.2 mg percent. At 17 weeks' gestation, the patient underwent neck exploration with removal of a 2.5 cm x 2.0 cm right inferior parathyroid adenoma. The postoperative course was uncomplicated; at discharge, her serum calcium was 8.5 mg percent. The hyperemesis abated by week 20 and the patient gained 30 pounds during the remainder of her pregnancy.

At 37 weeks, the patient delivered vaginally a healthy male infant weighing 6 pounds 10 ounces with an Apgar score of 9 at birth and of 10 at five minutes. The newborn's serum calcium was 10.1 mg percent; the patient's calcium was 8.4 mg percent.

DISCUSSION

"Nausea and vomiting of pregnancy" generally is restricted to a mild disorder during early pregnancy characterized especially by morning nausea and sometimes by vomiting. Although the nausea and vomiting may be quite distressing and persist throughout the day, the patient does not develop fluid and electrolyte derangements. Treatment consists of reassurance that the condition is temporary, and an antiemetic drug without teratogenic potential can be prescribed.

Hyperemesis gravidarum or pernicious vomiting of pregnancy causes individuals to develop nutritional deficiency or fluid and electrolyte disturbances from intractable vomiting in early pregnancy. As in the milder cases, the onset of symptoms tends to be soon after the first missed menstrual period and almost always before the fifth month of gestation. Classically, the vomiting disappears during the third month and rarely persists into the fourth month, although Guze reported 60 percent of his patients had vomited during more than half of the pregnancy.¹ The reported incidence of hyperemesis gravidarum varies considerably; the average is 3.5 per 1,000 deliveries.

A pregnant woman also is susceptible to the same causes of nausea and vomiting as a nonpregnant person. The vast majority of patients, however, who have nausea and vomiting between the weeks 6 and 16 of pregnancy have no demonstrable structural lesion of the gastrointestinal tract. The diagnosis of nausea and vomiting of pregnancy or hyperemesis gravidarum cannot be assumed without consideration of alternative gastrointestinal disorders associated with vomiting. Fortunately, for ease of diagnosis, most such disorders as gastroesophageal reflux, peptic ulcer, biliary colic, pancreatitis, and bowel obstruction are accompanied by pain and usually are quite easy to exclude. The possibility of drug-induced nausea or hyperthyroidism must be excluded as well.

Primary hyperparathyroidism is uncommon and the actual incidence is unknown, but the incidence in all women of childbearing age (approximately eight new cases per 100,000 population per year) suggests that hyperparathyroidism in pregnancy is more frequent than the literature would indicate.

The first case was described by Friedrichsen in 1938, and this is the 80th reported case.² The discrepancy between expected and observed suggests that hyperparathyroidism may be a relatively benign complication of gestation which is unappreciated because of the infrequent determinations of serum calcium in otherwise uneventful pregnancies and the suppres-

sion of calcium levels, both total and ionic, into the lower limits of normal range by pregnancy, thereby masking mild hyperparathyroidism.

The diagnosis of primary hyperparathyroidism during pregnancy usually has been made postpartum after the appearance of neonatal tetany. The condition is associated with severe fetal complications, including spontaneous abortion, stillbirth, and prematurity; it is important that the diagnosis be considered when the mother experiences renal colic, peptic ulcer, pancreatitis, bone pain, or hyperemesis despite calcium levels that may be in the normal range.

In 1962, Ludwig found a 49 percent incidence of complications in 39 pregnant women who had hyperparathyroidism with spontaneous abortion, stillbirth, and neonatal death occurring in 31 percent and neonatal tetany in 18 percent.³ Shangold's review in 1982 documented a 46 percent perinatal and 45 percent neonatal complication rate in cases of maternal hyperparathyroidism.⁴ Perinatal mortality has decreased to a rate of 2 percent as a result of improved diagnostic and therapeutic modalities.

In considering the pathogenesis of neonatal tetany associated with maternal hyperparathyroidism, one must first understand normal serum calcium dynamics during pregnancy. As early as the second trimester, adjustments in maternal calcium metabolism result in enhanced gastrointestinal absorption and increased total body accretion of calcium.⁵ This reserve facilitates transporting to the fetus approximately 25 to 30 gm of calcium by term for skeletal mineralization. The first event noted in the second trimester is a physiologic decrease in serum albumin resulting in a progressive decrease of serum ionic calcium to the lower normal range, where it remains until term. The fall in ionized calcium is followed by a rise in parathyroid hormone levels by week 21 to 24.⁶ This has been considered as physiologic hyperparathyroidism of pregnancy with hormone assays twice normal noted at term. The 25-hydroxy-vitamin D levels decrease and 1,25-dihydroxy vitamin D ($1,25(\text{OH})_2\text{D}$) levels start increasing in the first trimester when parathyroid hormone levels generally are depressed.⁷ The 25-hydroxy vitamin D is converted into $1,25(\text{OH})_2\text{D}$ by the enzyme 1,25-dihydroxylase. It is suggested that the increased activity of 25-hydroxy vitamin D₁ alpha hydroxylase may be due to a combination of estrogen and progesterone with a possible role of human placental lactogen.⁸

Ertel et al. demonstrated that neonatal tetany occasionally is accompanied by fetal hypomagnesemia in addition to hypocalcemia.⁹ Hypomagnesemia in the fetus results from maternal hypomagnesemia; magnesium deficiency is known to inhibit both synthesis and release of parathyroid hormone, even in the face of hypocalcemia. Elevated calcitonin levels provide protection to the mother's skeleton from the adverse effects of elevated parathyroid hormone levels and 1,25-dihydroxy vitamin D levels.

The calcium regulation of the fetus is determined by active placental transport mediated by the calcium ATPase system. Vitamin D and its metabolites cross the placenta but have little role in fetal calcium metabolism; maternal parathyroid hormone does not cross the placenta. Parathyroid hormone levels almost

are undetectable at term in the cord blood. The parathyroid gland of the fetus has the capacity to function as early as week 12 or 13. During pregnancy, calcium ion freely crosses the placenta from the maternal to fetal circulation. A relative mild elevation of calcium levels in the fetus plays a role in the suppression of the fetal parathyroid gland. However, this suppression may be more marked in the case of maternal hypercalcemia. Because of this, the neonate at birth may have difficulty mobilizing the calcium stores from its bones, resulting in tetany. Usually, the infant can be managed successfully by supplemental calcium, dietary phosphate restriction, and vitamin D. If neuro-irritability persists despite normalization of calcium levels, the replacement of magnesium along with restriction of milk containing high phosphates should be considered.

Some women with primary hyperparathyroidism have no symptoms during pregnancy; pregnancy produced a progressive decrease in serum total and ionized calcium throughout gestation. Others with mild symptomatic hypercalcemia can be controlled with oral phosphate therapy. Hyperparathyroid (hypercalcemic) crisis can occur when the serum calcium is elevated to 15 to 20 mg/dl and is associated with an acute and rapidly progressive clinical deterioration characterized by muscle weakness, fatigue, nausea and vomiting, anorexia, weight loss, dehydration, drowsiness, and confusion that may progress to coma and death. Such significant hypercalcemia can be controlled before surgery with saline diuresis with a calciuretic diuretic. Hypercalcemia that is resistant to diuretic therapy may be alleviated by more potent agents such as calcitonin and careful patient monitoring followed by parathyroidectomy on an urgent, individual basis.

Medical management should be used only for short-term control of hypercalcemia and not as long-term therapy. The pregnant patient with primary hyperparathyroidism should be treated surgically. The operation should be carried out after week 16 of gestation when fetal organ systems are developed. In the last trimester, the potential for premature labor becomes


progressively greater with approaching term. Thus, the optimal time to perform the neck exploration is the second trimester. To date, there have been no maternal deaths among patients who underwent parathyroid surgery during pregnancy. This patient represents the 27th reported case of parathyroidectomy during pregnancy since the first reported by Petit and Clark in 1947.¹⁰⁻¹⁵

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COMBINED PERCUTANEOUS AORTIC VALVULOPLASTY AND PERCUTANEOUS CORONARY ANGIOPLASTY

JACOB I. HAFT, M.D., JONATHAN E. GOLDSTEIN, M.D., JOHN A. ALTIERI, M.D.,
ARNOLD SCHONMULLER, M.D., NEWARK*

Significant aortic stenosis and single-vessel coronary disease were treated successfully without surgery in a patient with very poor left ventricular function. Percutaneous transluminal coronary angioplasty and balloon valvuloplasty provide another nonsurgical avenue for treating high-risk cardiac patients.

Balloon valvuloplasty of the aortic valve in the elderly has become a feasible and acceptably safe procedure.¹⁻⁴ Balloon angioplasty of critical coronary artery stenosis is effectively performed in patients more than 65 years old.⁴⁻⁶ Because the risk of combination coronary artery bypass surgery with aortic valve replacement is estimated at 13.5 percent⁷ and increases to approximately 17 percent in elderly patients,^{7,8} attention has been directed towards avoiding cardiac surgery by performing aortic valvuloplasty and percutaneous transluminal coronary angioplasty (PTCA) in the same patient.^{9,10} We describe the first combination of these procedures in New Jersey.

CASE REPORT

A 67-year-old white man had a one-year history of increasing angina, and dyspnea on exertion. He had orthopnea for the previous five weeks. The history included a possible attack of acute rheumatic fever as a child and rejection by the army in 1942 because of a heart murmur. Physically active all of his life, the patient had worked as a mail carrier. Cardiac catheterization was performed at another hospital in 1973. He was told his "arteries were open" and that he had aortic stenosis which did not require surgery at that time. There was no history of palpitations, light-headedness, or syncope.

The patient was a well-developed, well-nourished male with blood pressure 160/70 and pulse of 76/minute and regular. The carotid upstroke was diminished. Examination of the heart revealed the point of maximal impulse to be displaced 2 cm to the left of the midclavicular line, a 3/6 holosystolic murmur at the apex, a 3/6 harsh systolic ejection murmur at the base that radiated to the carotids, and a 2/6 diastolic murmur along the left sternal border. The aortic second sound was decreased in intensity; no opening snap was heard. Electrocardiogram showed normal sinus rhythm with complete left bundle branch block; chest x-ray confirmed cardiomegaly. Echocardiogram revealed a dilated diffusely hypokinetic left ventricle with a markedly thickened trileaflet aortic valve and a minimally thickened mitral valve with no evidence of mitral stenosis. Doppler study demonstrated a 60 mmHg gradient across the aortic valve, mild aortic insufficiency, and mild mitral regurgitation.

On cardiac catheterization performed via cutdown in the right brachial artery and an antecubital vein, the patient had marked pulmonary hypertension

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Figure 1—The 20-mm diameter aortic valvuloplasty balloon has been fully inflated within the stenotic valve. There is a Swan-Ganz catheter with a pacing wire in position. Note the balloon guidewire within the left ventricle (posterior-anterior projection).

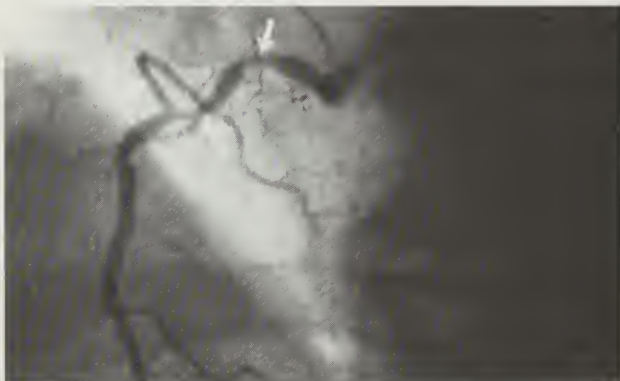


Figure 2—Coronary arteriogram of the right coronary artery (left anterior oblique projection). Note the high-grade narrowing in the proximal area.

(PA = 64/32 (44)), no gradient across the mitral valve, an aortic gradient of 34.5 mmHg, left ventricular end diastolic pressure (LVEDP) of 36 mmHg, and cardiac output of 3.3 liters/minute. The aortic valve area was calculated to be 0.5 cm². Left ventriculography revealed mild mitral regurgitation, and generalized severe hypokinetic contraction with an ejection fraction of 21 percent. There was one to two plus aortic insufficiency through a calcified aortic valve found on aortic root injection. Selective coronary arteriography demonstrated two areas of 90 percent stenosis in the proximal third of the right coronary artery (RCA) and intraluminal abnormalities with no hemodynamically significant stenosis in the left anterior descending (LAD) and the left circumflex (LCF) coronary arteries.

Because of the expected high risk of surgical aortic valve replacement and coronary bypass grafting in this patient with a severely dysfunctional left ventricle and pulmonary hypertension, we recommended aortic valvuloplasty combined with PTCA. It was decided that valvuloplasty should be performed first.

The patient was brought to the catheterization suite on January 5, 1988, and both femoral artery areas were prepared for catheter entry. A 5F cannula was placed in the left femoral artery and an 8F cannula was placed in the left femoral vein. A 7F Swan-Ganz pacing catheter was advanced through the left femoral vein into the pulmonary artery and pressures were recorded. A cutdown was performed over the right femoral artery and a 12F sheath was placed in the exposed right common femoral artery. Through this sheath, a Jud-

kins R-4 catheter was advanced to the aortic valve. With the aid of a straight flexible guidewire, the Judkins R-4 catheter was brought through the aortic valve and into the left ventricle. Upon removing the guidewire, left ventricular pressure was 168/30 and femoral artery pressure was 136/70, yielding a mean aortic gradient (by planimeter) of 39.4 mmHg at rest. Multiple thermodilution cardiac outputs were performed immediately and averaged 3.26 liters/minute; the functional aortic valve orifice area at rest was calculated to be 0.53 cm².

A 260-cm long exchange wire with a double-coiled flexible distal tip was brought through the Judkins R-4 catheter; the Judkins catheter was removed. A 20-mm balloon dilatation catheter was brought over the exchange wire through the femoral sheath, advanced through the aorta, and placed across the aortic valve. Four inflations using dilute contrast medium were performed (Figure 1). Each inflation was maintained at a pressure of two and one-half to three atmospheres for 30 to 55 seconds. During balloon inflation ventricular ectopy occurred, and systemic arterial pressure fell transiently to a mean of 40 to 50 mmHg. After completion of the four inflations, the balloon was withdrawn over the exchange wire and a pigtail catheter was brought over the exchange wire and placed in the left ventricle; the exchange wire then was removed entirely. Left ventricular pressure following angioplasty was 160/30 and systemic pressure simultaneously measured in the left femoral artery was 132/72. Planimetric measurement of the gradient was 31.3 mmHg following valvuloplasty. Multiple thermodilution cardiac outputs again were performed averaging 3.74 liters/minute. Utilizing the Gorlin equation, the functional orifice area following balloon valvuloplasty was calculated to be 0.74 cm². The gradient was confirmed by catheter pullback, and the entire catheter system was removed from the right femoral artery. The arterial puncture was repaired surgically and the skin incision was closed by the thoracic surgeon who was in attendance throughout the procedure.

The patient was on heparin with catheters maintained in the left femoral vein and artery in the coronary care unit. Two days later, he returned to the catheter laboratory for angioplasty of the right coronary artery. After administering 10,000 units of heparin, the left femoral artery indwelling cannula was replaced with an FR-4 guiding catheter, using an exchange wire; it was maneuvered into the right coronary ostium. A 2.5 mm low profile steerable (LPS) short balloon was brought across the proximal severe stenosis in the right coronary artery. Three inflations to ten atmospheres were performed, with each inflation lasting from 40 to 50 seconds. The balloon was advanced to the second stenosis and two inflations were performed to six atmospheres. The angioplasty balloon was withdrawn and repeat arteriography was performed through the guiding catheter in the right coronary artery. Repeat arteriography demonstrated near-complete resolution of both of the discrete proximal stenoses in the right coronary artery (Figures 2, 3, and 4). The left ventricle (LV) was entered and on pullback, the mean aortic valve gradient was 19 mmHg. The guiding catheter was removed and the patient returned to the coronary care unit for observation on

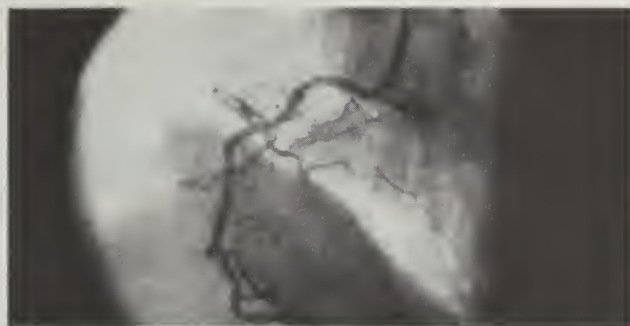


Figure 3—Coronary arteriogram following successful angioplasty of the right coronary artery.

intravenous heparin. The next day after stopping the heparin infusion, the Swan-Ganz catheter and indwelling 8-French femoral arterial lines were removed. The patient tolerated the procedures without problems. During the remainder of his hospitalization, the patient was free of angina, his orthopnea resolved, and he experienced no dyspnea on ambulation. He has remained asymptomatic.

DISCUSSION

Until recently, the only effective therapy for aortic valvular stenosis in the adult had been surgical aortic valve replacement. In 1986, Cribier et al. demonstrated that critically stenotic aortic valves could be opened without thoracotomy using percutaneous balloon dilatation of the valve.¹² The success of this procedure, even in heavily calcified valves, has been confirmed repeatedly over the past two years.¹⁻⁴ The interventional therapy of choice for single-vessel coronary artery occlusive disease has become percutaneous transluminal angioplasty.^{5,6} Because valvuloplasty still is a new procedure and long-term followup may demonstrate a significant number of patients in whom aortic stenosis recurs,¹³ the procedure has been reserved for elderly patients who are very poor candidates for surgery, and symptomatic patients who adamantly refuse surgery. This patient was severely symptomatic and many of the findings that increase the risk of aortic valve surgery were present: a dilated, dysfunctional, failing left ventricle,⁷ pulmonary hypertension,⁷ and associated coronary artery disease.⁸ The patient's coronary lesion was optimum for PTCA, and we felt that valvuloplasty would be tolerated better by his dilated ventricle than would open heart surgery.

Combination PTCA and aortic valvuloplasty has been reported in 13 patients. Hamad and colleagues successfully performed aortic valvuloplasty and right coronary angioplasty on three patients, and valvuloplasty and LAD PTCA on one patient.¹⁰ McKay et al. reported nine patients who had the combination therapy.⁹ PTCA with associated aortic valvuloplasty was performed in three LAD, three LCF, two RCA, and one graft to the RCA. Hamad did PTCA as the first procedure in patients because he felt reducing the hypoxic insult during the stress of valvuloplasty would be beneficial. McKay also did PTCA first in 8 of the patients; two procedures were performed on one visit to the catheter laboratory because of technical considerations, and valvuloplasty was performed first in the patient who had staged procedures.

We chose to perform combination valvuloplasty and PTCA rather than surgery in our patient primarily



Figure 4—Aortogram in the left anterior oblique progression performed after valvuloplasty and after coronary angioplasty demonstrating one plus aortic insufficiency.

because of the very poor LV function. We reasoned that if he had acute closure of the coronary as a result of PTCA (crashed) and he still had severe aortic stenosis, this further insult to his already weakened LV would make his chances of survival very much compromised. Alternatively, we felt that he would tolerate, without major difficulty, the less than 60 second episodes of severe LV outflow obstruction that occur during aortic valvuloplasty, even in the presence of the severe right coronary lesion. Hence, we elected to perform valvuloplasty first and follow it with PTCA.

Addendum: Another patient successfully underwent combined aortic valvuloplasty and PTCA. Thus, 5.1 percent (2/39) of the aortic valvuloplasties performed at St. Michael's Medical Center have been combination procedures.

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TEN-YEAR EXPERIENCE IN OTOLARYNGOLOGY MEDICAL MALPRACTICE CLAIMS IN NEW JERSEY

HARVEY P. YEAGER, M.D., AND SUZANNE L. KUEHM, M.P.H., LAWRENCEVILLE*

Educating patients to have realistic expectations of procedural outcomes and to communicate effectively with patients, especially when a negative result occurs, appear to lower the risk of a medical malpractice suit. By listening to patients, many suits, particularly those involving diagnosis errors, could be avoided.

The United States General Accounting Office Report published in 1987 states that "the best way to deal with medical malpractice is to prevent its happening." While it is too ideological to suggest that all medical malpractice suits can be prevented, an awareness of specialty-specific trends can be the first step for the physician in developing a personal risk prevention plan to reduce professional liability.

The risk prevention department of the Medical Inter-Insurance Exchange of New Jersey (MIENJ), a physician-owned carrier, was established on February 1, 1983, by its Board of Governors. One of the objectives of the department is to decrease patient injury and reduce medical malpractice claims and their impact upon the physician—emotional, professional, and financial. A system was developed to analyze all claim files to identify trends to facilitate risk prevention activities. These files were divided into surgical, non-surgical, and anesthesia categories, then subdivided into specialty categories. The department analyzes and codes all cases based on problem areas identified by the peer review process.

The peer reviewer is of the same medical specialty as the physician involved in the lawsuit. The peer reviewer is responsible for educating the medical liability representative and the lawyer as to the medical problem. The majority of the cases reported here have been

determined indefensible by peer review or by the defendant physician. There also was a small number of cases that resulted in verdicts for the plaintiff.

The data used in this paper is based on the claim experience of otolaryngologists (Table 1) insured from February 1977 through February 1987 (Table 2). The number of otolaryngologists that were insured during these ten years averages 99 physicians per year.

The first phase of the review includes cases closed with payment to the claimant. We have considered that actual medical misadventures occurred in these claims.

CASES CLOSED WITH PAYMENT

All cases closed with payment since the inception of MIENJ were analyzed. There were 79 cases closed with a total indemnity payment of \$5,335,257.68. Payments ranged from \$32 to \$630,000. The average indemnity paid was \$67,534.90. The expense incurred in the defense of these cases was \$335,432.73, an average of

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TABLE 1
Anatomical Areas

Categories	No. of Files
Head and Neck Surgery	15
Facial Plastic	12
Ear	10
Nose and Sinus	6
Tonsil C/S Adenoid (only one tonsil case involved a major life-threatening complication)	6
Endoscopic	5
Teeth	18
Miscellaneous	7

\$4,245.98. Only 15 insureds had two or more cases, 5 insureds had three or more cases, and only 1 insured had more than four cases. This doctor no longer is insured by MIENJ. During the same time period, there were 188 cases closed without indemnity payment. There were 40 open files.

ERRORS IN DIAGNOSIS

There were ten cases with a total of \$1,437,178.00 paid to the claimant. Of these ten cases, there were two cases of delayed diagnoses of cancer of the larynx (9 and 18 months delay). The patients were 52 and 63 years old, respectively. There was one case with a two-year delay in diagnosis of cancer of the pyriform sinus and larynx in a 48-year-old; one case with a one-year delay in diagnosis of cancer of the parotid gland in a 40-year-old; one case with a 10-month delay in diagnosis of cancer of the pharyngeal wall in a 55-year-old; and one case with a one-year delay in diagnosis of cancer of the tongue in a 47-year-old.

You should listen to what your patients are trying to tell you.

The following case example is a representation of these claims. A 63-year-old male had bilateral benign polyps removed from the true vocal cords. Six months later, the patient returned complaining of hoarseness. Indirect laryngoscopy revealed a white spot on the true vocal cord. "Impression was a return of leukoplasia. The patient was scheduled to return for observation in one month." At this visit (one month later), indirect laryngoscopy revealed the "white spot" still was present. The insured recommended observation in three months. A review of the office records showed symptoms listed on every office visit (weight loss, hoarseness, coughing with blood-tinged sputum production, and sore throat). The patient eventually was seen by a second physician who made the diagnosis of cancer of the larynx and performed a total laryngectomy and bilateral radical dissection. The physician peer reviewer felt that due to the patient's history, the insured should have been more aggressive since he had suspected cancer when he removed the polyp nine months earlier. The reviewer opined that the patient should have been admitted for a direct laryngoscopy.

When you suspect something is not right, do not wait before you act upon your suspicions.

Trends. There were several likenesses found among

the cases involving errors in diagnosis: (1) The patient's symptoms were treated over a period of time without improvement or consideration of another diagnosis. The insureds took a "watch and wait" attitude. There was no re-evaluation. The patient sought treatment from another physician who made the correct diagnosis. (2) There was a failure by the physicians to followup on recommendations of consultants or second opinion otolaryngologists for further diagnostic study. (3) The insureds were lulled into a false sense of security by negative test results and negative physical findings by other specialists, even though there was no improvement in the patient's symptoms.

ERRORS IN PERFORMANCE

Of the 15 cases in this category, 6 cases involved rhinoplasty/septoplasty; 2 cases involved stapedectomy; 2 cases were for nasal polypectomy, ethmoidectomy and arthroscopy; and 1 case involved tracheostomy. There were several issues common to all 15 cases: (1) The operative consent did not advise of the risk of the complication occurring. This especially was important when the patient had a pre-existing condition that placed him at special risk of the complication occurring. For example, a patient had a septoplasty. Following surgery, the patient was noted to have multiple perforations in the septum. This patient was at greater risk of this occurring since he had prior nasal injury with surgical repair. (2) In the cases which involved rhinoplasty, the patients expressed dissatisfaction with the result. One patient made the comment, "He told me I was going to look like Robert Redford." Perhaps more time spent with these patients preoperatively to help them formulate a more realistic expectation of the surgery would prevent this type of claim. (3) In cases involving stapedectomies, the patients alleged that there was a decrease in hearing following surgery. In these cases, the insureds had not performed preoperative audiograms. In both of these cases, the physician recommended re-exploration but the patient refused or postponed the second surgery and later sued the physician for the delay in performing the re-exploration.

Educate the patient to promote realistic expectations of procedural outcomes and of your own abilities.

In one case within this category, the patient's family had requested one surgeon to perform a tracheostomy and had signed an operative consent naming that physician alone. When a partner of the designated surgeon performed the tracheostomy, the family sued the two operating physicians for battery, and sued the requested physician for a deviation from the standard of care.

UNINTENTIONAL IATROGENIC INJURY

In this category there were 13 cases. Eight cases were nerve injuries which accounted for \$1,194,475.00 of the total indemnity for this category (\$1,362,762.00). There were 4 facial nerve injuries as a result of ear surgery; 2 spinal accessory nerve injuries and 1 brachial nerve injury arising from the removal of neck tumors; and 1 third cranial nerve injury from a bilateral Caldwell Luc procedure. Other significant major injuries occurred to blood vessels during sinus

TABLE 2
Ranking of Misadventures
by Percent of Total Indemnity (\$5,451,125.94)

Misadventure	No. of Files	Indemnity Paid	% of Total Indemnity Paid
Error in Diagnosis (failure, delay, or misdiagnosis)	10	\$1,437,178	26.36
Unintentional Iatrogenic Injury (unintentional injuries occurring during the performance of a therapeutic procedure)	13	\$1,362,762	25.00
Decision Error	8	\$1,111,702	20.39
Error in Performance (of a procedure)	15	\$1,028,500	18.87
Legal Issue	1	\$150,000	2.75
Records	4	\$126,499	2.32
Management (relied on assessment of resident)	1	\$99,000	1.82
Communication Breakdown (between patient and doctor)	2	\$39,500	0.72
Error in Medication	3	\$38,999	0.72
Communication Breakdown (between care providers)	1	\$30,000	0.55
Potentially Compensable Event (tooth injuries)	18	\$13,485	0.25
Surgical Foreign Bodies	2	\$11,000	0.20
Consultation/Referral Problems	1	\$2,500	0.05

surgery. It is interesting that there were no nerve injuries arising from surgery to the parotid gland.

There were several lessons to be learned in this category: The patient needs to be counseled thoroughly preoperatively to be made aware of the risks inherent in the procedure. And, when a negative outcome occurs, the manner in which the situation is handled can make a difference in the patient's decision to sue. Listen to the patient and heed the patient's complaints. A delay in diagnosing a cerebral spinal fluid leak or meningitis following nasal polypectomy or sinus surgery, or a delay in diagnosing an invasion of the orbit following sinus surgery, only compounds the initial complication.

Know your surgical instruments and their safety features.

DECISION ERRORS

There were eight files in this category and a total of \$1,111,702 paid in indemnity to claimants. There was no commonality in conditions being treated or in the surgical procedures performed. We note several case reports:

Case Report 1: A 37-year-old obese male was diagnosed as having acute epiglottitis. From the time the patient arrived at the hospital, there was a 30-minute

delay at the information desk, and an additional 30 minutes before the primary physician saw the patient and then wheeled him to the x-ray department. At this time, the primary physician telephoned the otolaryngologist, who requested x-rays of the neck. The otolaryngologist arrived 15 minutes later, and read the x-ray films as indicating severe swelling of the epiglottis, arytenoid cartilages, and probably of the subglottic area as well. He obtained a history of progressively more difficulty in breathing. His examination demonstrated severe inspiratory and expiratory stridor. The larynx could not be examined because the patient could not lift his head from the flexed position. The patient was in the operating room 20 minutes after the insured's examination. There was yet another delay of 15 minutes until the operating room became available and an additional delay until the anesthesiologist arrived. The patient had a respiratory arrest just prior to the tracheotomy being performed by the insured—one hour and 45 minutes after the patient had arrived at the hospital. The patient expired one hour later in the intensive care unit. It was that physician reviewer's opinion that the insured should have called the operating room himself and obtained a backup anesthesiologist, and as the situation became more emergent, a cricotracheotomy should have been performed.

Case Report 2: A 57-year-old woman had a total rhinostomy for an infiltrating squamous cell carcinoma. She was readmitted for reconstructive surgery where the insured connected a deltopectoral skin flap to the nose. The patient was kept immobile postoperatively. On postoperative day 6, an infection was recognized at the chest site, and within the following week the reconstruction effort was considered a failure. The insured admitted that this was the first time he had performed this procedure. The physician reviewer opined that a forehead flap should have been used instead of the chest flap.

Case Report 3: A 30-year-old male complaining of a choking sensation was diagnosed as having an elongated uvula. The insured removed the elongated uvula, and the patient suffered from excessive bleeding necessitating a second admission for blood transfusions containing factor VIII. The patient was a known hemophiliac. The peer reviewer advised that the inflamed uvula was not life threatening, and knowing that the patient was a hemophiliac, the insured should have treated the patient conservatively.

Do not be reluctant to ask for a second opinion, especially if the patient is not improving or if there has been a surgical complication.

Trends. In each of the eight cases in this category, there appears to be one common thread. While it may be easy to say in retrospect that a decision was not the best for the patient, in each of the previous examples where an atypical problem was identified, "a second thought" before instituting treatment may have resulted in an alternate treatment and avoidance of these negative outcomes. Perhaps a second thought, "Is this the right treatment for this patient or for this situation?" might help avoid similar situations. A similar concept is stated in the book, *In Search of Modern Hippocrates*: "I as a physician, shall recommend for each patient only those things I would like to have done for myself or my immediate family under the same circumstances."² (This does not mean to imply that we recommend that the physician actually treat his own family members.)

POTENTIALLY COMPENSABLE EVENT

While there were 18 claims against our insureds for injury to teeth occurring during a procedure, the indemnity paid ranged only from \$32.00 to \$725.00. It is of significance that in most of the cases, it was specifically documented that a tooth protector or a dental guard had been used, but the pressure from the weight of the scope and the manipulation damaged the teeth. Eleven of the 18 procedures that led to the injuries were laryngoscopies, while 5 procedures were tonsillectomies. There was only 1 case each of bronchoscopy and esophagoscopy.

THE REMAINING MISADVENTURES

The remaining 15 files did not produce any trends. We have included several case reports from these files where a breakdown in the treatment environment (office procedures) led to the medical malpractice suit:

Case Report 1. A 22-year-old male's preoperative blood test indicated a bleeding abnormality. The hospital telephoned the insured's office with the test results. **The office staff did not alert the physician. The test**

results were placed into the hospital chart, but the physician did not review the chart before surgery. The surgery was elective and the patient was not acutely ill. Postoperatively, the patient had serious bleeding, was maintained in the intensive care unit, had a lengthy hospitalization, and had several additional hospital admissions for recurrent bleeding. This should emphasize the need for an office system that ensures that information is promptly and accurately relayed directly to the physician.

Case Report 2. Dexamethasone (Decadron®) was prescribed for a 55-year-old female to treat nasal congestion due to an allergy over a period of three years. The physician saw the patient for seven office visits. On three of these office visits, the physician noted in the record that the patient was taking the dexamethasone, and he advised her to stop the medication. The patient alleged in the suit that as a result of taking the dexamethasone, she developed diabetes mellitus and personality changes. (Continuous, prolonged, unmonitored prescription of dexamethasone is a deviation from the standard of care.) The physician's contention was that he had not continued to prescribe the drug and wasn't aware that the patient was still taking the drug. However, there are telephone calls where the insured states he may have ordered dexamethasone with no documentation of the telephone calls or prescription in the office record. **Important decisions and outcomes often are dependent upon information relayed via the telephone through the office staff and answering service. There is a need to carefully record and make these messages a part of the patient's chart.**

Case Report 3. A 37-year-old female was referred for evaluation of a mass of the parotid duct as seen on the x-ray. The otolaryngologist diagnosed a tumor. Upon exploration of the parotid duct, no tumor was found. The patient suffers from numbness of the face and Frey's syndrome. The patient is alleging unnecessary surgery which was improperly performed. Two weeks prior to surgery, Partner A noted in the office record that the patient's face was normal and surgery was not indicated. Partner B disagreed with Partner A and performed surgery. There are two important points to be made: the record should always reflect the physician's thought process. In this example, possibly Partner A changed his opinion and agreed with the need for surgery but failed to document this in the patient's record. Secondly, take care not to be a facilitator of a medical malpractice suit by carelessly worded comments in the patient's record or through casual verbal comments. **A final word in regard to records: frequently a claim could not be defended because the insured had altered the patient's record. Don't be tempted to alter records.**

CONCLUSION

In this paper we have reviewed the ten-year experience in medical malpractice claims closed with payment in the specialty of otolaryngology. MIENJ paid \$5,335,257.68 in indemnity for 79 claims in an insured population that averaged 99 otolaryngologists per year.

Diagnostic errors with decision errors represent \$2,548,880 in losses in 18 suits. Improper perfor-

mance of a procedure with unintentional iatrogenic injuries represents \$2,391,262 in losses in 28 suits. These four misadventure categories represent 46 of the 79 files and 90.62 percent of the total indemnity paid to claimants.

For the purpose of increased patient safety and decreased medical malpractice claims, we recommend consideration of the following points:

1. **Listen to the patient's complaints when making a diagnosis, and listen carefully to complaints following surgery.** This may save you from a delay in diagnosis or a failure to diagnose a condition, and may aid in the timely diagnosis of complications from surgery or unintentional iatrogenic injuries such as a severed optic nerve or meningitis secondary to sinus surgery. We have seen case after case where the physician turned a deaf ear to the patient. Problems could have been avoided just by taking a detailed history or by listening. If the patient is not improving with your treatment, consider "second thoughts" and second opinions to aid in diagnosing the unusual or difficult condition. If there has been a second opinion and there are worthwhile suggestions, carry them out.

2. **Have an ongoing dialogue with your patients to educate them in developing realistic expectations of treatment, of surgical outcomes, and of your own abilities.** This may lessen the chance of being sued for a poor result which in reality was a reasonable risk. Explain to the patient and family the risks of the procedure, and document the discussion in the patient's record. When an unexpected injury does occur as a result of a surgical procedure, be honest and open in your explanation to the patient. Take immediate steps to correct or treat the problem, or refer the patient to the appropriate person or facility where remedial care can be provided. Be supportive to the patient and family in the resolution of the complication.¹

3. **Don't be coerced by the patient into doing a procedure** if you feel you may not be the best person to do the procedure, or if you believe the treatment or procedure is not appropriate.

4. **Document the patient's refusal to comply with recommended treatment.** This should include that the patient was given sufficient information to appreciate the seriousness of the condition, and the risks involved in refusing or delaying treatment in order to make an informed decision.

5. **Do not alter records.** Any addition or deletion made to the patient's record, especially after a bad result or negative outcome, will make the entire record suspect and greatly diminish the defensibility of the physician.

6. **Operate under nonparalytic anesthesia when possible.** There have been several cases of major nerve injury during head and neck surgery that might have been avoided if the patient had not been under paralytic anesthesia.

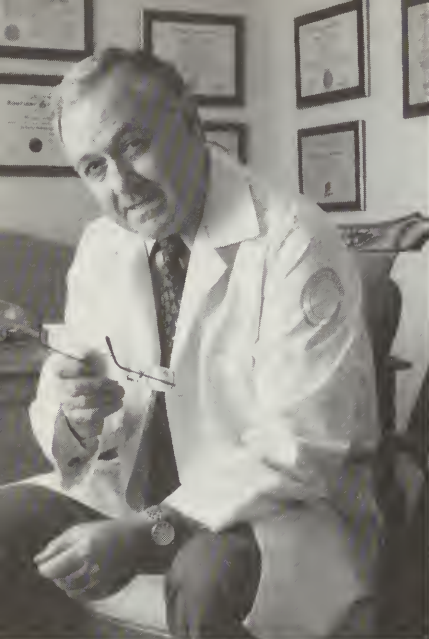
7. **Recognize that a breakdown in office procedure can be as likely to engender a medical malpractice suit as an improperly performed procedure.** Examples of costly office procedure errors are x-ray reports being filed without the physician seeing them or a telephone message never relayed to the physician.

We hope the experiences of your colleagues will help otolaryngologists develop a personal system of loss prevention.

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STATE OF THE ART: EFFECTIVE PALLIATIVE RADIOTHERAPY AND QUALITY OF LIFE

ANDREW I. ZABLOW, M.D., LIVINGSTON*

Radiation therapy is highly effective in providing symptomatic palliation to patients with metastatic cancer. Irradiation is cost effective, maintains functional status, and provides good quality of life in a percentage of patients.

Cancer is the second highest cause of death in the United States. In 1980, it accounted for approximately 21 percent of all deaths and in 1986, about 25 percent (one out of every four) deaths in America.¹ In 1988, over 900,000 new cancer cases will be reported together with over one half million deaths. The harsh statistics reveal that a child born in 1986 has a greater than one-in-three chance of developing an invasive carcinoma during his lifetime. With better trained oncologists using improved modes of therapy, cancer patients are living longer with productive, quality lives. Fifty percent of all recently diagnosed cancer patients will be alive in five years.

Radiation therapy is an effective therapeutic tool when used to treat patients with incurable metastatic disease (Table). It is utilized to relieve pain, control hemorrhage, and to alleviate obstruction and compression of visceral organs.

BONE METASTASES

Bone metastases frequently are seen in cancer patients. Over half of the patients with breast, prostate, and bronchogenic carcinoma will develop skeletal metastases during the course of their disease; 80 percent of all bone metastases develop from these three primary sites.² Other primary malignancies that will metastasize to bone include thyroid cancer and

cancers of the urologic tract. Multiple myeloma is a primary malignancy in bone marrow.

Patients with osseous involvement will suffer from pain, disability, and, occasionally, pathologic fracture. Pain which often is localized and gradually increasing in intensity, is produced by periosteal destruction or direct tumor pressure. It commonly is associated with weight-bearing bones.

Before initiating therapy, it is important to determine the extent of skeletal involvement. Greater than 50 percent cortical destruction places the patient at high risk for pathologic fracture. When weight-bearing bones are involved, an orthopedic surgical consultation concerning internal fixation is required. This often will prevent fracture, provide pain relief, and keep the patient functional. Radiotherapy (RT) is added to control and prevent further progression of metastases.

For other patients not requiring orthopedic intervention, RT is highly efficacious in alleviating pain. Various published reports have shown long-term pain relief in 73 to 96 percent of patients.^{3,6} Pain relief is often experienced before completion of short course palliative treatment. Within approximately three

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TABLE

Treatment Sites and Response to Radiotherapy

Metastatic Site	Response % with Radiotherapy
Bone	73-96
Brain	70-90
Intrathoracic	80
Liver	55-95
Intrapelvic	75
Spinal Cord	
Compression	35-75
Superior Vena Cava	80-90
Cutaneous	90

months of completion of treatment, recalcification is seen by serial radiographs in many patients. One study reports a 78 percent rate of recalcification.⁵

In selected patients with widespread symptomatic metastases, hemibody irradiation has been used with great success. Single doses of 600 to 800 cGy delivered to the upper, lower, or mid hemibody will provide relief to over 70 percent of patients. Most noted relief within the first 24 to 48 hours.^{7,9} Special pretreatment medications and corrections for lung density will minimize the side effects and make them very tolerable. Relief usually endures for the remainder of the patient's life.

Successful management of osseous metastases is essential to maintaining a good quality of life for the cancer patient. Survival after the diagnosis of metastatic bone disease often is prolonged. For this reason, physicians should be cognizant of the therapeutic and prophylactic values of radiation therapy. Prompt localized irradiation can reduce symptoms, maintain or improve function, and provide a good quality of life.

BRAIN METASTASES

Brain metastases commonly are seen by the radiation oncologist in over 80 percent of patients presenting with multiple brain foci. Lung and breast carcinoma are the most common primary sites. Headaches, seizures, personality changes, and/or other neurologic symptoms are common presentations. Computerized tomography or MRI will delineate the lesions.

Treatment involves a combination of irradiation and steroids. The majority of patients receive whole brain radiotherapy with doses of 30 Gy in two weeks sometimes followed by a boost treatment in three weeks. The median survival for patients with multiple brain metastases is four to six months. Response rates are greater than 80 percent with 60 percent experiencing neurologic improvement for the remainder of their lives.

LIVER METASTASES

In the patient with hepatic metastases, symptoms may include pain, nausea, vomiting, anorexia, jaundice, and ascites. With radiotherapeutic intervention, 55 to 95 percent of patients will experience significant pain relief, reduction in hepatomegaly, and improved liver function studies.¹¹ Fractionated doses of 2100 cGy in two weeks often are used. Median survivals after treatment range from four to six months. This is

slightly improved in patients with untreated disease, but if symptoms are relieved, a great service has been provided. Studies using combination radiotherapy, chemotherapy, and monoclonal antibodies have been encouraging.

INTRATHORACIC METASTASES

Large metastatic nodal masses can cause pain and obstruction. Radiation therapy is used to shrink masses and alleviate or prevent symptoms. Total doses and treatment volumes are determined by the type and extent of the disease.

Esophageal compression and airway obstruction are common problems associated with metastatic disease to the mediastinum and thorax. Palliation of pain and dysphagia have been reported in up to 84 percent of patients treated with a short split course of radiotherapy, which is extremely well tolerated with minimal side effects.¹²

Pleural effusions that have been refractory to other treatment modalities have shown response to radiotherapy. By employing a moving strip technique to the involved hemithorax that delivers 18 to 20 Gy in six fractions over eight days, control rates are approximately 80 percent.¹⁶ This is a short, facile, effective treatment for controlling recurrent malignant effusions.

INTRAPELVIC METASTASES

Patients presenting with advanced local pelvic malignancies, e.g. gynecologic, prostatic, or rectosigmoid carcinomas, may benefit from palliative radiotherapy. Many of the patients present with pain, rectal or vaginal hemorrhage, discharge, and obstruction. Pelvic irradiation can relieve rectal or ureteral obstruction by reducing the size of pelvic masses which are causing extrinsic compression. Vaginal or rectal hemorrhage can be controlled in 75 to 100 percent of the cases. Various fractionation schedules have been used with good success. We have found that a split course utilizing 25 Gy in two weeks and repeated four weeks later will palliate symptoms in almost every patient.

CUTANEOUS METASTASES

Ulcerative, painful skin lesions which often are seen with metastatic carcinoma, readily are controlled with localized radiotherapy. A very high percentage of these lesions respond to treatment with low-energy electrons with minimal epidermal reactions.

ONCOLOGIC EMERGENCIES

Untreated spinal cord compression will cause permanent neurologic damage to the patient. The physician should be alerted to the patient who presents with a combination of gradually increasing pain, weakness, autonomic dysfunction, sensory loss, or ataxia. Pain, by far, is the most common symptom, being present in 90 percent of patients. Ninety-five percent of spinal cord metastases are epidural, most commonly secondary to cancers of the breast, lung or prostate, or lymphomas. Radiation therapy alone, or radiation following laminectomy in certain cases, must be instituted as soon as possible once the diagnosis is made. A high degree of suspicion allows for early diagnosis and improved prognosis. The outcome is

improved markedly in patients presenting with partial compression and minor neurologic dysfunction. As many as 75 percent of patients who are ambulatory at the time of diagnosis of compression will remain ambulatory after treatment. Various fractionation schedules are used with the outcome dependent upon the type of disease and the degree of neurologic dysfunction at presentation.^{13,14}

Superior vena cava syndrome also requires prompt intervention. Patients present with shortness of breath, tachypnea, plethora, thoracic and neck vein distention, pain, cough, and dysphagia. Using a few initial large dose fractions of radiotherapy combined with steroids and followed by standard daily fractionation to a total dose of 30 to 35 Gy will provide improvement in 80 to 90 percent of the patients in 10 to 14 days.¹⁵

SUMMARY

The realistic goals in palliative treatment of cancer patients are to maintain functional status and to provide as good a quality of life as possible. This is achievable through the expertise provided by the treating radiation oncologists using modern computerized treatment planning and highly penetrating x-ray beams. The morbidity of treatment has been reduced markedly. Treatment most often can be given in an outpatient setting. Radiation therapy has proved to be the most cost-effective and humane means of relieving the symptoms of local cancer.

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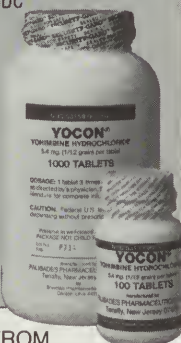
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OPINION: CLINICAL USE OF URINE TESTING IN RELAPSE PREVENTION

WILLIAM J. ANNITTO, M.D., AND CHARLES A. DACKIS, M.D., RANCOCAS*

Urine testing is a major therapeutic tool in preventing and monitoring relapse. Urine monitoring must be clinically tied directly to consequences within the treatment plan. Urine testing should include: strict supervision; high frequency of testing; and patient informed consent to discuss drug-related issues with relevant others.

Treatment for substance abuse implies a commitment on the part of the patient and the clinician. Until this time, the addict has been committed only to acquiring and ingesting drugs. Addicts' initial view of treatment is that clinicians simply are one more hurdle to "get over" so that they may continue to acquire and ingest more drugs. They literally have no notion as to how or why to achieve sobriety. As you know, addicts frequently come into treatment only under extreme duress and generally with multiple medical, psychiatric, legal, or social problems.

How does urine testing fit into the treatment of substance abuse? Urine testing is a very concrete, specific, objective tool in treatment. Interestingly, it serves the needs of the most objective of clinicians and the most subjective of clinicians (Tables 1 and 2). Urine testing serves simultaneously as a rigid indicator of compliance as well as to reinforce in the patient many positive psychological factors that we are trying to encourage. Specifically, it demonstrates to the patient that we have limits, and that we take seriously the true meaning of sobriety, i.e. a clean urine. It demonstrates that we will not and cannot be manipulated by words. However, it also is the entree into their trust on a truly intrapsychic level. They know we realize their cravings are real. We know they have a real disease. In a very physical sense, it tells them that we do care about

them, and that they must behave in a certain way in order for us to treat them in a certain way. Words will have become more than instruments for manipulation. Behaviors will count more than urine screens. The incentive to comply with urine screening is built into an ongoing treatment plan. It clearly and forcefully encourages the treatment goals.

The ultimate goal of drug treatment is sobriety, on the one hand, and an improvement in the quality of life psychologically and psychosocially on the other hand. The patient begins from the point of, "I need to be detoxed and this is what is in my urine," and he achieves a point of, "This is what happened at the office today. These are my feelings, can we talk about them." To get to that point, however, one has to proceed with outpatient treatment in an orderly fashion through the treatment plan, and this creates consequences for the production of a dirty urine (Table 3). The failure to produce a clean urine may mean: 1) inpatient treatment; 2) increased meeting attendance; 3) loss of job; 4) loss of family; 5) loss of licensure; 6) repeat testing with serum and/or a more specific test with, for instance, an enzyme immunoassay or radioimmunoassay. At the least, it will

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TABLE 1
Objective Factors with Urine Testing

- Supervised
- Specific
 - Time
 - Place
 - Substance
- Personal responsibility—it is the patient's urine
- Limit setting
- Words are not important
- Behaviors are important

TABLE 2
Subjective Factors with Urine Testing

- Increases patients' trust in towards treatment
- Recognizes that cravings are real
- Patients have a real disease
- We are not controlling them

TABLE 3
Consequences of a Dirty Urine

- Inpatient treatment
- Increase number of meetings
- Job loss
- Family loss
- Licensure revocation
- Repeat testing with more sensitive tests

mean the clinician has to review the treatment plan with the patient and perhaps with important others. These consequences for failure to produce a clean urine should have been in the treatment plan. They are not foisted upon the patient at the time of the occurrence. For instance, a physician whose license may be on the line, will have been participating actively in the program with the knowledge that should he fail to attend a meeting or should he deposit a dirty urine, there would be the consequence of loss of licensure. Most programs that specialize in treating licensed categories of patients, physicians, attorneys, or nurses, have extremely high compliance for this reason. They have many clean urine tests and very good meeting attendance. This reinforcement of the treatment goals may seem self-evident to us. However, for some addicts, failure at two or three programs is not uncommon. At some point, however, they will have to believe in their own ability to achieve sobriety and in our firm conviction that they can attain it.

When a dirty urine is produced, the only way it works clinically as a monitoring safeguard for the patient is if there are consequences. As a support and stimulant for patient motivation, I have found that clinically there is no stronger tool. It is of clinical note that in

all my years and untold thousands of urine screens, no one has ever admitted to a positive urine. Addicts will confess when confronted with the clinical evidence of relapse: missed meetings, absenteeism, borrowing money from peers, or change in a new found interest; or they deny drug use to the end. That is to say, they deny it in the face of positive urine screens. Yet, alcohol has to be consumed. The denial of drug use in the face of positive testing denotes an extremely severe degree of psychopathology. The grandiosity, the negation of the importance of the other, and the temerity of the addict are all important characterological aspects of the drug addict that need to be psychotherapeutically addressed before an addict can achieve sobriety. Unfortunately, such treatment could take years. The pragmatic adherence to an effective limit, i.e. dirty urine, is the only effective resource in preventing relapse.

There is no clinical correlation between behaviors and words in the treatment of substance abuse. One of the greatest dangers of a psychotherapeutic approach to the treatment of the drug addict is that the problem of drug abuse gets addressed only verbally. The addict will continue blithely to abuse drugs simply because no one has administered a urine screen.

Psychologically speaking, what does this mean? It means that the addict has not dealt with the issues of lying, grandiosity, manipulateness, negation of others, "both as objects and beings." That is to say, the addict will be placing his family in financial risk, himself at physical risk, and his spouse at physical risk (AIDS), and no one will be the wiser. Behaviorally, an addict still may be attending meetings, keeping therapist appointments, and dealing with issues. He may be maintaining his job. This situation is remarkable and frightening. Eventually, the shoe will drop, the drug addict will miss an appointment, fail to pay a bill, or ask to borrow money. Excuses will begin to pile upon excuses.

Total disruption of any treatment plan soon will follow. And, it continues because urine testing on a random basis was not done. Urine testing may be done, but if inadequately supervised, the test results are meaningless. Patients can take any number of extremely inventive approaches to passing fully supervised urine tests. They have stockpiled clean urines, bought or manipulated clean urines from others, added bleach to urine, drank vinegar, and taken natural diuretics and pharmaceuticals to diuresis a clean urine. Addicts can produce relatively warm urine from plastic spray containers, rubber hosing down the arm, or using the sink in the bathroom. An addict will skip an appointment because his car broke down, he worked overtime, or his grandmother died. What an addict is doing is wasting time until the next night or two nights hence, so the urine will be clean from the heroin used over the weekend (Table 4).

The detection of unsuspected drug use is difficult at best, and downright impossible if the clinician is not highly suspicious. Thus, it is a clinical truism that in the outpatient treatment of drug addicts, only two things are important, urine testing reports and behaviors. As soon as one changes negatively, the clinician must assume the patient has relapsed and the treatment plan needs to be revised or at least reviewed.

An outpatient treatment plan for drug addiction is confronted with denial about relapse almost everywhere (Table 5). The most common sources of relapse occur around the most common events: need for dental surgery, trauma—car accident, new losses—in the family; holiday reemergence of untreated medical or psychiatric problems—specifically depression; new signs of the old disease; and change of treatment plan without prior discussion with a therapist or counselor. This list is not complete. Clinical examples include treating patients with antidepressants, anticonvulsants, and antipsychotics; which can be a critical and crucial part of recovery. Unfortunately, there is little data on this topic. When I had a patient on antidepressants going from inpatient to outpatient treatment who discontinued the antidepressants without prior consultation, I can say with clinical surety that he was having severe urges and not dealing with relapse issues at groups or in therapy. I can predict that if a patient managed to manipulate the discontinuation of medications with his physician's approval, he generally would relapse within a month.

An illustrative example concerning dental surgery will prove this point. A dental surgeon will give the patient a prescription for Percodan® as the patient is leaving the office. The patient will fill the prescription, follow the recommended schedule, and deposit a dirty urine. What do you do? What does this mean? Again, the treatment plan has to be reviewed. It may mean that clinically we made a mistake by not placing the patient on the opiate receptor blocker, naltrexone. Alternatively, it may mean that the patient needs to be confronted about the issue of denial and taking back control of treatment, or it may mean that the patient needs to be rehospitalized because he will begin to discuss severe uncontrollable urges and cannot be maintained in less than a highly structured environment.

Whatever the source of the denial, there is no greater source of clinical justification of revising a treatment plan than a positive urine screen (Table 6). It is a concrete, specific, palpable demonstration that the patient perhaps is out of control with drug abuse. Certainly, the patient will have begun to utilize old coping mechanisms like lying, negation, or manipulation. These issues would need to be confronted in therapy. The positive urine screen could be used to educate the family to the need for decreasing financial support or increasing the structure required by the patient. It can be used to increase the job jeopardy pressure on the patient. It can be used simply to confront the patient and allow him to make the decision as to whether he wants to approach his disease responsibly and coherently and continue in treatment, or risk loneliness, loss of family, financial damage, and self-destruction.

SUMMARY

Urine testing is a major therapeutic tool in preventing and monitoring relapse. Drug abuse can be viewed as a behavioral disease, not as a psychological or verbal disease. Hence, urine monitoring must be clinically tied directly to consequences within the treatment plan. This allows the clinician to become something other than another person to be manipulated by the

TABLE 4
<i>False Urines</i>
<ul style="list-style-type: none"> • Stockpiled urine • Using someone else's urine • Diuresis—natural, pharmacological • Additives <ul style="list-style-type: none"> —Bleach —Vinegar • Drink vinegar

TABLE 5
<i>Common Sources of Relapse</i>
<ul style="list-style-type: none"> • New Medical Problems <ul style="list-style-type: none"> —Dental —Trauma —Depression —Insomnia —Gambling —Sexual acting-out • Stress <ul style="list-style-type: none"> —Family loss —Job loss —Holidays • Previously untreated/unidentified problems <ul style="list-style-type: none"> —Medical/psychiatric —Boredom —Old friends —Spouse

TABLE 6
<i>Clinical Uses of Urine Monitoring</i>
<ul style="list-style-type: none"> • Document sobriety for job requiring licensure • Ego-gratifying for successful patient • Educate family • Confronts patient's pathological thinking • Document credibility of treatment • Accepts patient's symptoms as real • Clarifies goals

verbally skilled addict. Most clinically relevant urine testing should include: strict supervision of the urine taking; high frequency of taking urines—at least two a week, to prevent time lapse/drug metabolism; availability of a full range of urine tests; continuous testing throughout the treatment course; and patient informed consent to discuss all drug-related issues with relevant others.

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Thomas Russo, <i>Invited Guest</i>	Trenton
S. Eugene Yuliano, MD, <i>Invited Guest</i>	Trenton

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AMA-Education Research Foundation

(Liaison requested by AMA—October 7, 1951)

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(Appointment requested by the Medical History Society of
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(Requested by the National Society To Prevent Blind-
ness—New Jersey—March 19, 1978)

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Blood Bank Association, New Jersey

(Liaison requested by New Jersey Blood Bank Associa-
tion—April 25, 1969)

Frank Campo, MD Trenton

Blood Banking Task Force for New Jersey

(UMDNJ—October 1981)

Frank Campo, MD Trenton

Cardiac Rehabilitation Services Study Commission

(Established to study availability of such services in New
Jersey)

James U. Cardelia, MD Collingswood
R. Gregory Sachs, MD Summit
Arthur Bernstein, MD Millburn

Commissioner's Physician Advisory Committee

(Representation requested by State Commissioner of Health
to assist in the Diagnosis Related Group (DRG) con-
cept—June 1977)

Palma E. Formica, MD, *President** Old Bridge
*Douglas M. Costabile, MD, Murray Hill, First Vice-President,
designated as President's representative for 1988-1989.

Commissioner's Special Committee on Health Issues

(Representation requested by Commissioner of Health—July
1983)

Ralph J. Fioretti, MD Rochelle Park
Douglas M. Costabile, MD, *Alternate*,
First Vice-President Murray Hill

Dental Health, State Task Force for Better

(Representation requested by Department of Health—
January 30, 1985)

Glenn P. Lambert, MD Flemington

Diabetes Coordinating Council

(Representation requested by Department of Health—
November 10, 1980)

Arthur Krosnick, MD Princeton

Drug and Alcohol Problems, Statewide Committee To Assist Local School Districts with

(Representation requested by New Jersey State Department
of Education, Regional Curriculum Services Unit-South—
June 5, 1984)

Ed Reading, MDiv Lawrenceville

Drug Utilization Review Council, New Jersey

(Representation requested by Department of Health—
December 19, 1984)

Harry M. Woske, MD Flemington

Education, State Department of

(Liaison requested by the Assistant Commissioner of Educa-
tion—September 21, 1958)

Glenn P. Lambert, MD Flemington

Emergency Medical Personnel and Hospitals, Division on Women Training Program for

(Representation requested by the New Jersey State Depart-
ment of Community Affairs, Division on Women—August 2,
1984)

Rudolf E. Schwaeble, MD Mendham

Executive Committee

(Provided in the Bylaws, Chapter 111 (c))

Palma E. Formica, MD, *President, Chairman* .. Old Bridge
Paul J. Hirsch, MD, *President-Elect* Bridgewater
Douglas M. Costabile, MD,
First Vice-President Murray Hill
Joseph A. Riggs, MD,
Second Vice-President Haddonfield
Harry M. Carnes, MD, *Immediate*
Past-President Audubon
Bernard Robins, MD, *Secretary* Union
Joseph N. Micale, MD, *Treasurer* North Bergen

Graduate Medical Education, Advisory Council on

(Representation requested by UMDNJ—1979)

Stephen F. Wang, MD Morristown

Health Care Administration Board

(MSNJ staff representation—July 1983)

A. Ronald Rouse Lawrenceville

Health Maintenance Organization Projects, Advisory Com- mittee To Participate in the Review of

(Recommended to executive director, Statewide Health Coor-
dinating Council, Department of Health—1974)

Henry J. Mineur, MD Westfield

Highway Safety Policy Advisory Council, New Jersey

(Nomination for appointment by governor requested by direc-
tor, Department of Law and Public Safety, Division of Motor
Vehicles—March 19, 1984)

Martin E. Johnson Lawrenceville

Hospital Association, New Jersey

(Liaison established at request of New Jersey Hospital As-
sociation—December 17, 1967)

Paul J. Hirsch, MD, *President-Elect* Bridgewater

Hospital Medical Staff Section, Governing Council

(Hospital Medical Staff Section established by 1984 House of Delegates)

Harold S. Yood, MD, *Chairman* Plainfield
George T. Hare, MD, *Vice-Chairman* Haddon Heights
Angelo S. Agro, MD, *Secretary* Haddonfield
William W. Fithian, MD, *Delegate* Millville
Carlo Porcaro, MD, *Alternate Delegate* Newark
Francis J. Lumia, MD, *Member-at-Large* Allentown
Robert L. Wegryn, MD, *Member-at-Large* Elizabeth
Robert J. Weierman, MD, *Immediate*

Past-Chairman South Orange
Diana C. Gore, *MSNJ Staff Liaison* Lawrenceville

JEMPAC, Conference Committee with

(Established at request of JEMPAC—June 25, 1967)

Irving P. Ratner, MD, *Chairman*, Council
on Legislation Willingboro
Joseph W. Fleisher, MD, *Chairman*, Council on
Medical Services Bayonne
Joseph A. Riggs, MD, *Second*
Vice-President Haddonfield

Legislation

(1) Federal Keymen (Mechanism established by MSNJ—April 4, 1954—to serve as official intermediaries between MSNJ and the federal legislators): 14 Congressional District Keymen and 2 Senatorial Keymen.

(2) State Keymen (Mechanism established by MSNJ—July 13, 1952): Keymen in 40 Legislative Districts and 21 Component Societies.

Medical Assistance Advisory Council

(Established at the request of the New Jersey State Department of Human Services—1980)

James G. Atkinson, MD Vincentown
Thomas S. Bellavia, MD Hasbrouck Heights

Medical Assistants, New Jersey Society of

(Liaison requested by Association—September 15, 1963)

Giovanni Lima, MD Kearny
Joseph C. Lucci, *MSNJ Staff Liaison* Lawrenceville

Medical Liaison Committees

(High-level conference groups for discussion and consideration of items of mutual interest)

Palma E. Formica, MD, *President* Old Bridge
Paul J. Hirsch, MD, *President-Elect* Bridgewater
Douglas M. Costabile, MD,

First Vice-President Murray Hill

Joseph A. Riggs, MD, *Second*

Vice-President Haddonfield

Harry M. Carnes, MD, *Immediate*

Past-President Audubon

Bernard Robins, MD, *Secretary* Union

Joseph N. Micale, MD, *Treasurer* North Bergen

Vincent A. Maressa, *Executive Director* Lawrenceville

(1) Medical-Dental

(Liaison requested by Dental Society—June 10, 1951)

(2) Medical-Hospital

(Liaison established by MSNJ—October 25, 1953)

(3) Medical-Legal

(Liaison established by MSNJ—October 25, 1953)

(4) Medical-Nursing

(Liaison established by MSNJ—April 4, 1954)

(5) Medical-Osteopathic

(Liaison requested by Osteopathic Association—September 17, 1961)

(6) Medical-Pharmaceutical

(Liaison established by MSNJ—July 26, 1953)

Mental Retardation, Governor's Council on the Prevention of

(Appointed by the governor—June 22, 1984)

Stanley S. Bergen, Jr, MD Newark

Osteopathic Physicians and Surgeons, NJ Association of

(Invitation to attend Board meetings extended to MSNJ president—July 24, 1986)

Palma E. Formica, MD, *President* Old Bridge

Pharmaceutical Assistance to the Aged and Disabled Advisory Council

(Appointed by commissioner of the Department of Human Services—physician representation requested by Division of Medical Assistance and Health Services—December 19, 1980)

Frank J. Malta, MD Toms River

Pharmacopeial Convention, The United States

(Delegate authorized to be seated—August 1988)

Joseph N. Micale, MD, *Treasurer* North Bergen

Poison Information and Education System, Advisory Board to New Jersey

(Representation requested by Department of Health—January 21, 1983)

Rudolf E. Schwaeble, MD Mendham

Radiation Protection, Advisory Committee on Nuclear Medicine to New Jersey Commission on

(Consultants in nuclear medicine appointed by Commission—November 20, 1966)

Henry J. Powsner, MD Princeton

Radiation Protection, Consultant Serving New Jersey Commission on

(Nomination for appointment to Commission requested March 17, 1963)

Frank Gingerelli, MD Hackensack

Resolutions, Committee on Annual Meeting

(Established by Board of Trustees July 18, 1971, to review all resolutions in advance of the Annual Meeting)

Ralph J. Fioretti, MD, *Chairman*, Committee

on Annual Meeting Rochelle Park

Edward A. Schauer, MD Farmingdale

Harry M. Carnes, MD Audubon

Safety Council, New Jersey State

(Provided in Council Bylaws—1962)

Palma E. Formica, MD, *President* Old Bridge

Society for the Assistance of New Jersey Physicians and their Families, The

(Liaison requested by Society—May 17, 1959)

Joseph R. Jehl, MD Clifton

State Board of Medical Examiners

(Member of MSNJ executive staff to attend monthly meetings, Board of Trustees—August 8, 1979)

Martin E. Johnson Lawrenceville

Statewide Health Coordinating Council (SHCC) and/or its Review Committee

(Liaison established January 15, 1978)

A. Ronald Rouse Lawrenceville

Student Association, Medical Society of New Jersey

(Formed July 17, 1977)

Palma E. Formica, MD, *President* Old Bridge

Uninsured, Steering Committee on Health Issues of the

(MSNJ participation requested by Department of Health—March 7, 1986)

Vincent A. Maressa Lawrenceville

UMDNJ, Foundation of the

(MSNJ representative appointed yearly by the Board of Trustees to serve as a trustee, pursuant to the Bylaws of the Foundation—1979)

Arthur Bernstein, MD South Orange

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UMDNJ Notes; Physicians Seeking Location in New Jersey

UMDNJ Notes

**Stanley S. Bergen, Jr., MD
President**

On November 8, you will have the opportunity to cast a vote for the \$350 million "Jobs, Education and Competitiveness Bond Act of 1988," a bond issue which would provide funding for much-needed construction and renovation projects at New Jersey's colleges and universities as well as support for new programs in science and technology.

UMDNJ will benefit directly from the funds generated by the bond issue, since \$25 million of the total is earmarked for our projects. In combination with institutional matching funds, these funds will support construction and expansion of needed facilities to house important educational and research programs at our campuses in northern, central, and southern New Jersey.

These funds are of vital importance if we are to continue our advancement toward excellence and national prominence. To build upon the progress we have made already, we must have the facilities which will permit the growth and refinement of our programs.

Therefore, I ask that you join me in casting a vote for a strong state health sciences university. On election day, please vote yes for the "Jobs, Education and Competitiveness Bond Act."

I am pleased to announce the appointment of Dr. Norman Edelman, a member of our faculty for 16 years, as dean of the Robert Wood Johnson Medical School. This appointment was made following an intensive national search.

An acknowledged authority in the field of pulmonary medicine, Dr. Edelman joined the school in 1972 as professor of medicine and chief of the pulmonary disease division. He has served with distinction as a teacher, clinician, researcher, and administrator as the acting dean, and as the medical school's associate dean for research. As interim director of the Center for Advanced Biotechnology and Medicine at the Piscataway campus, Dr. Edelman played a major role in helping to establish this important advanced technology center.

Dr. Edelman is a member of the governing council, New Jersey Thoracic Society. His several other professional endeavors include membership on the editorial boards of the *Journal of Applied Physiology* and the *American Review of Respiratory Diseases*. Dr. Edelman was serving as acting dean prior to his appointment.

A special University-wide task force has been formed to develop a Minority Health Institute that will be dedicated to addressing issues related to the health status of minorities and the disadvantaged in New Jersey.

The Institute's mission will be to analyze risk factors associated with preventable morbidity and premature mortality among blacks, hispanics, other minorities, and poor populations in the state and to develop and recommend priorities that establish measurable interventions for those risk factors.

The University has embarked on this action in part as a response to published national studies which show that minority populations experience about 60,000 more deaths per year than white populations.

In addition to identifying specific risk factors and preventive measures, the proposed Institute will promote educational opportunities

and the recruitment and retention of minorities into health care fields. It also will offer information to the community, health professionals, and government agencies on means to reduce the impact of major risk factors associated with illness and death.

The task force has proposed that the Institute focus on four main areas. They are: development of a data bank on minority health risk factors; development of new health education programs that emphasize awareness and prevention; establishment of research programs to help further our understanding of health problems affecting minorities and the poor; and development of a fundraising component to help support Institute projects.

Joining me on the Minority Health Task Force are 18 colleagues representing our campuses throughout the state. George Hampton, our vice-president for urban and community affairs, is task force chairman. A project director is being recruited to help organize the Institute and begin implementing its programs.

UMDNJ's long-standing commitment to providing educational opportunities for minority and disadvantaged youth is reflected in our special summer programs designed to improve academic skills and to spark interest in health-related careers. This summer, more than 200 young students participated at all three of our campuses.

In Newark, the pre-college program, which is cosponsored by several area institutions, devoted six weeks to instruction and counseling for 125 high school pupils.

In both Newark and Piscataway, a small group of young scholars on our Minority High School Science Apprentice Programs participated in research projects with New Jersey Medical School and Robert Wood Johnson Medical School faculty members.

And more than 100 Camden youths studied math and science as part of the Camden Science Pipeline project at our School of Osteopathic Medicine. A majority of the students already had participated in the project's first phase, called the Early Bird Program. The overall plan takes promising students through several phases, including a college level component, all designed to help prepare students for health careers.

Congratulations are extended to members of our faculty for these achievements:

Dr. Joel A. DeLisa, professor and chairman of the Department of Rehabilitation Medicine at New Jersey Medical School, has been appointed a director of the American Board of Physical Medicine and Rehabilitation. Dr. DeLisa, who also is medical director and chief medical officer of the Kessler Institute for Rehabilitation in West Orange, becomes one of ten board members of the organization.

Dr. DeLisa's prominence in his field was underscored with the recent publication of his book, *Rehabilitation Medicine: Principles and Practice*, published by J.B. Lippincott, of Philadelphia. The book, with contributions from more than 100 specialists, is an outstanding resource for a growing medical field.

Two physicians on the faculty of the School of Osteopathic Medicine have been elected distinguished practitioners in the National Academy of Practice in Osteopathic Medicine. They are: Dr. Charles Steiner, professor and chairman, and Dr. Eleanor V. Masterson, associate

professor, in the Department of Clinical Osteopathic Sciences at the school.

The National Academy of Practice in Osteopathic Medicine is one of nine National Academies of Practice founded to advise the Congress on health matters. Each academy limits its membership to 100 medical professionals and only ten distinguished practitioners are elected by their peers each year for their contributions to health care practice.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY—Grant H. Greeley, M.D., 6305 Snow Heights Ct., El Paso, TX 79912. SUNY Downstate 1979. Also, internal medicine. Board certified. Also, board certified (IM). Partnership or multi-

specialty group within commuting distance of New York City. Available May 1989.

GASTROENTEROLOGY—Howard P. Fritz, M.D., 14 Baldwin Ct., Newington, CT 06111. St. Louis 1984. Also, internal medicine. Board eligible. Board certified (IM). Available July 1989.

K. Suresh Reddy, M.D., 280 Henderson St., #16J, Jersey City, NJ 07302. Kakatiya Medical College (India). Also, internal medicine. Board eligible. Board certified (IM). Solo or group. Available June 1989.

INTERNAL MEDICINE—Howard P. Fritz, M.D., 14 Baldwin Ct., Newington, CT 06111. St. Louis 1984. Also, gastroenterology. Board certified. Available July 1989.

Grant H. Greeley, M.D., 6305 Snow Heights Ct., El Paso, TX 79912. SUNY Downstate 1979. Also, allergy. Board certified. Also, board certified (ALLERGY). Partnership or multispecialty group within commuting distance of New York City. Available May 1989.

K. Suresh Reddy, M.D., 280 Henderson St., #16J, Jersey City, NJ 07302. Kakatiya Medical College (India). Also, gastroenterology. Board certified. Solo or group. Available June 1989.

NEURORADIOLOGY—Jerome G. Wiot, M.D., 803 East 6th St., #401, Newport, KY 41071. Cincinnati 1982. Board certified. Group or academic. Available July 1989.

ORTHOPEDIC SURGERY—Paul Bizzigotti, M.D., 230 E. 12 St., #7A, New York, NY 10003. NYU 1981. Board eligible. Group or partnership. Available. Joseph M. Grant, M.D., Naval Hospital, Box 8, FPO, San Francisco, CA. UMDNJ 1980. Board eligible. Group or partnership. Available July 1989.

PEDIATRICS—Elizabeth Lubas, M.D., 508 Third St., Lyndhurst, NJ 07071. Boston University 1986. Board eligible. Group or partnership. Available. Iraj Modarai, M.D., 40 Cherry Hill, Springfield, VT 05156. Tabriz (Iran) 1956. Polyclinic 1963. Board certified. Clinic, emergency, salary. Available.

PHYSICAL MEDICINE AND REHABILITATION—Robert B. Thorne, M.D., 1219 East Northern Pkwy., Baltimore, MD 21239. Rutgers 1980. Board certified. Available.

RADIOLOGY—Joseph M. Ullman, M.D., 148 Chestnut Crossing Dr., Apt. I, Newark, DE 19713. George Washington 1984. Board eligible. Group, partnership, community hospital, outpatient imaging center. Available July 1989.

UROLOGY—Joseph G. Colonna, M.D., 503 Captain Dement Dr., Waldorf, MD 20601. Guadalajara 1977. Board certified. Group, partnership, solo. Available.

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Category: (Please check one)

☐ Member, MSNJ ☐ Subscriber, NJ Medicine

☐ Other _____

Name _____

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PEDIATRIC UPDATE 1989

**Pierre Marques, Acapulco, Mexico
January 3-8, 1989.**

Sponsored by: Schneider Children's Hospital of Long Island Jewish Medical Center, New Hyde Park, NY. Faculty: Philip Lankowsky, M.D., Herbert T. Abelson, M.D., David L. Rimoin, M.D., and E. Richard Stiehm, M.D. Credits: 18 Hours Category 1 ACCME, AMA and AAFP. Information: Office of Continuing Education, Schneider Children's Hospital of LIJMC, New Hyde Park, NY 11042; (718) 470-8650.

ACUPUNCTURE & ELECTRO-THERAPEUTICS IN CLINICAL PRACTICE

NY State Boards of Medicine & Dentistry 25-hour accredited seminar & workshop on the latest theories & techniques of manual and electro-acupuncture, TENS & simple non-invasive diagnostic methods (including cardio-vascular & neuromuscular systems & "Bi-Digital O-Ring Test"), applicable toward the 300-hour requirement for MDS & DDS acupuncture certification, will be given for licensed clinicians (with or without prior training) the weekend of **Dec. 9-11, 1988** at the Milford Plaza Hotel, 45th St. and 8th Avenue, Manhattan. The **4th International Symposium on Acupuncture & Electro-Therapeutics**, with many world leading scientists & clinicians will be held at the Columbia University Sch. of Int. Affairs, NYC, **Oct. 13-16, 1988**. (about 40 credit hours) Co-sponsored by the Int. College of Acupuncture & Electro-Therapeutics; its official journal, *Acupuncture & Electro-Therapeutics, Res., Int. J.* (published by Pergamon Press, indexed in 15 major indexing periodicals: Index Medicus, etc.); Heart Disease Research Foundation; Neuroscience Dept. & NY Pain Ctr., Long Island College Hospital; (SUNY-Brooklyn Health Science Ctr.); Nordic Medical Acupuncture Society; & Schmerz-Therapeutische-Kolloquium (W. Germany); etc. Also eligible for AMA/CME credit, category 1. For info on meetings or submission of papers, contact Y. Omura, MD, ScD, 800 Riverside Drive (8-I), NYC 10032. Tel: (212) 781-6262 or (212) 928-0658, or P. Shinnick, PhD, (212) 941-0870 or Brother Michael (212) 920-0162.

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**Ft. Lauderdale
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**New Orleans
December 10-11**

**Los Angeles
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The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization for further information.

ALLERGY

November

- 6- In Vitro Allergy Seminar: Update 1988**
Various times—Trump Plaza Hotel and Casino, Atlantic City
(Holy Name Hospital)
- 11 Asthma and Allergies**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton
(Bridgeton Hospital)

December

- 9- Allergy and Nutrition**
- 11 7:30 A.M.-4:30 P.M.**—The Pointe at Tapatio Cliffs, Phoenix, Arizona
(Holy Name Hospital)

ANESTHESIOLOGY

November

- 2 Pain Therapy**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)
- 15 Anesthesia and the Burn Patient**
6-10 P.M.—Ramada Inn, Clark
(NJSSA)

CARDIOLOGY

November

- 2 Newer Cardiac Drugs**
1:30-2:20 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)
- 7 Advanced Cardiac Life Support**
- 8 6 P.M.**—Freehold Area Hospital, Freehold
- 16 (Freehold Area Hospital)**
- 15 Thromboembolism and Thrombolytic Therapy**
12 noon-1 P.M.—Hospital Center at Orange, Orange
(AMNJ)

- 17 Indications for Noninvasive Studies**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

December

- 1 Valvuloplasty**
11 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and Medical Center)
- 8 How To Decide on Therapy for Acute Myocardial Infarction**
12 noon-1:30 P.M.—Somerset Medical Center, Somerville
(AMNJ)
- 15 Newer Cardiac Drugs**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)
- 20 Advances in the Treatment of Arrhythmias**
9-10 A.M.—Holy Name Hospital, Teaneck
(Holy Name Hospital)

MEDICINE

November

- 1 Gastric Obstruction**
1-2 P.M.—West Hudson Hospital, Kearny
(West Hudson Hospital)
- 2 Infections in the Elderly**
8:15 A.M.—Center for Health Affairs, Princeton
(UMDNJ)
- 2- New Leads into Cellular Processes**
- 4 9 A.M.-5 P.M.**—UMDNJ, Piscataway
(UMDNJ)
- 2 Emergency Care**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)
- 2 Cholesterol**
9-10:30 A.M.—Somerset Medical Center, Somerville
(Somerset Medical Center)
- 3 Extracorporeal Shock Wave Lithotripsy**
11 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and Medical Center)
- 4 Recent Advances in the Management of Epilepsy**
Robert Wood Johnson Medical School, New Brunswick
(UMDNJ)
- 4 Calcium Blockers and the Kidney**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton
(Bridgeton Hospital)
- 7- Clinichem 1988**
- 8 9 A.M.-5 P.M.**—Sheraton Tara, Springfield, MA
(Northeast Alliance of the American Association for Clinical Chemistry)
- 8 Uses of New B-Lactam Antibiotics**
9-10 A.M.—Holy Name Hospital, Teaneck
(Holy Name Hospital)
- 9 Rational Use of Antibiotics**
7-9 P.M.—The Villa Mattar, Allamuchy

(Hackettstown Community Hospital)

- 9 Clinical Management of HIV Infection**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)
- 9 Brain Death**
1-2 P.M.—West Hudson Hospital, Kearny
(West Hudson Hospital)
- 9 Medical Lecture Series**
- 16 10:30-11:30 A.M.**—Christ Hospital, Jersey City
- 30 (Christ Hospital)**
- 10 Clinical Update in the Management of the Critically Ill Patient**
8 A.M.-5 P.M.—The Hyatt, Cherry Hill
(NJ Society of Critical Care Medicine)
- 10 Management of Continuous Ambulatory Peritoneal Dialysis**
1:30-2:30 P.M.—Vineland Developmental Center, Vineland
(AMNJ)
- 10 Meeting of the New Jersey Society of Critical Care Medicine**
Hyatt, Cherry Hill
(NJ Society of Critical Care Medicine)
- 15 Malpractice**
10-11 A.M.—Green Brook Regional Center, Green Brook
(AMNJ)
- 15 Immunology in Type I Diabetes**
9-10 A.M.—Holy Name Hospital, Teaneck
(Holy Name Hospital)
- 15 AIDS—Medical Malpractice, Criminal Law, and Tort Issues**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)
- 16 Proper Use of Endoscopy**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)
- 16 Pain Management**
1-2 P.M.—West Hudson Hospital, Kearny
(West Hudson Hospital)
- 16 Evaluation and Management of Kidney Stones**
1:30-2:30 P.M.—RCHP, 57 U.S. Highway 1, New Brunswick
(Rutgers Community Health Plan)
- 16 Annual Scientific Meeting of the Academy of Ophthalmology and Otolaryngology**
8 A.M.-4:30 P.M.—Aspen Conference Center, Parsippany
(Academy of Ophthalmology and Otolaryngology)
- 17 Modern Management of Arthritis**
12 noon-1:30 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center)
- 18 E.C.R.P.**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton
(Bridgeton Hospital)
- 29 Relationship Between Aspirin and Bronchial Asthma**
9-10 A.M.—Holy Name Hospital,

THE PHILADELPHIA HEART INSTITUTE
of Presbyterian—University of Pennsylvania Medical Center

CARDIOLOGY UPDATE

designed for the physician and provides an intensive survey of the
current status of clinical cardiology

Wednesday
November 2, 1988
3:00-5:30 PM

**Controversy: Should Cardiac Catheterization be
Performed Routinely After Myocardial Infarction?**

Moderator
Bernard L. Segal, M.D.

3:00-3:30 Yes Jai B. Agarwal, M.D.
3:30-4:00 No Adrian S. Weyn, M.D.
4:00-5:00 Case Presentations Walter R. Hepp, M.D.
Panel Discussion Norman Feinsmith, M.D.
Leonard N. Horowitz, M.D., Terry Langer, M.D.
Jan R. Weber, M.D., Adrian S. Weyn, M.D.

- No Registration Fee
- Reception following session
- CME Credits*
- Call for Reservation 662-8627

* * *

Scheie Eye Institute Auditorium
Presbyterian—University of Pennsylvania Medical Center
39th and Market Streets
Philadelphia, Pennsylvania
Parking Available (at discount rate).

* * *

* The University of Pennsylvania School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing education for physicians. The University of Pennsylvania School of Medicine designates this continuing medical activity for 2 credit hours per session in Category I of the Physicians Recognition Award of the AMA.

- Teaneck
(*Holy Name Hospital*)
- 29 Septic Shock**
12 noon-1 P.M.—Hospital Center at
Orange, Orange
(*AMNJ*)
- 30 New Physician Program**
8 A.M.-4:30 P.M.—MSNJ
Headquarters, Lawrenceville
(*MIENJ*)

December

- 2 Thermography**
11:30 A.M.-12:30 P.M.—St. Lawrence
Rehabilitation Center,
Lawrenceville
(*St. Lawrence Rehabilitation
Center*)
- 2 Hyperlipidemia**
12 noon-1 A.M.—Bridgeton Hospital,
Bridgeton
(*Bridgeton Hospital*)
- 2 Developmental Disabilities:
Specific Dysfunctions**
1-2 P.M.—Woodbine Developmental
Center, Woodbine
(*AMNJ*)
- 6 Antibiotics and Renal Disease**
9-10 A.M.—Holy Name Hospital,
Teaneck
(*Holy Name Hospital*)
- 6 Problems in Neoplastic
Management**
7-8 P.M.—West Hudson Hospital,
Kearny
(*West Hudson Hospital*)

- 7 Living Wills**
10:30-11:30 A.M.—Christ Hospital,
Jersey City
(*AMNJ*)
- 7 Early Office Recognition of
Depression**
1:30-2:30 P.M.—Essex County
Hospital Center, Cedar Grove
(*AMNJ*)
- 7 New Dimensions in Medical
Education**
Learning Center, Englewood
Hospital, Englewood
(*Association for Hospital Medical
Education of New Jersey*)
- 8 Conservative Management of
Osteoarthritis and Indications for
Total Joint Arthroplasty**
11 A.M.—St. Joseph's Hospital and
Medical Center, Paterson
(*St. Joseph's Hospital and Medical
Center*)
- 9 How To Live To Be 106**
12 noon-1 P.M.—Bridgeton Hospital,
Bridgeton
(*Bridgeton Hospital*)
- 13 The Pharmacologic Management
of Pain**
9-10 A.M.—Holy Name Hospital,
Teaneck
(*Holy Name Hospital*)
- 13 Nutritional Support**
12 noon-1 P.M.—Hospital Center at
Orange, Orange
(*AMNJ*)
- 14 Emphasis on Significant Length
and Quality of Life as**

**Preconditions for Approval for
Organ Transplantation**
1-2 P.M.—West Hudson Hospital,
Kearny
(*West Hudson Hospital*)

- 14 Organ Procurement—Clinical
Aspects**
10:30-11:30 A.M.—St. Mary's
Hospital, Passaic
(*AMNJ*)
- 14 How To Heal a Broken Heart**
6:15-9 P.M.—Perona Farms,
Sussex County
(*Hackettstown Community
Hospital*)
- 16 Burns**
2-3 P.M.—Woodbridge
Developmental Center, Woodbridge
(*AMNJ*)
- 16 Combined Oral/Insulin Therapy of
Diabetes**
12 noon-1 P.M.—Bridgeton Hospital,
Bridgeton
(*Bridgeton Hospital*)
- 23 Anaerobic Infections**
7-8-8:30 A.M.—Atlantic City
Medical Center, Atlantic City
(*AMNJ*)

NEPHROLOGY

November

- 10 Management of Continuous
Ambulatory Peritoneal Dialysis**
1:30-2:30 P.M.—Vineland
Developmental Center, Vineland
(*AMNJ*)
- 15 Interventional Strategies in
Diabetic Nephropathy**
6:30-9 P.M.—Overlook Hospital,
Summit
(*Nephrology Society of
New Jersey*)

OBSTETRICS/GYNECOLOGY

November

- 6- Third Annual Issues and
9 Controversies**
7 A.M.—Contemporary Hotel, Lake
Buena Vista, Florida

ONCOLOGY

November

- 3 Cancer Research Colloquium**
10 3-4 P.M.—New Jersey Medical
17 School, G-506B, Newark
(*UMDNJ*)
- 14 Colon-Rectal Cancer**
7-8 P.M.—Wallkill Valley General
Hospital, Sussex
(*AMNJ*)
- 17 Tumor Board Conferences**
12 noon-1 P.M.—Newcomb Medical
Center, Vineland
(*Newcomb Medical Center*)

December

- 1 Cancer Research Colloquium**
8 3-4 P.M.—New Jersey Medical,
15 School, G-506B, Newark
22 (*UMDNJ*)
29
- 7 Unproved Dietary and Nutritional
Methods in Cancer Prevention
and Treatment**
9-10:30 A.M.—Somerset Medical
Center, Somerville

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*,
Medical Society of New Jersey, Two Princess Road, Lawrenceville,
NJ 08648, at least six weeks before you move.

Category: (Please check one)

☐ Member, MSNJ ☐ Subscriber, NJ Medicine

☐ Other _____

Name _____

Old Address _____

City _____ State _____ Zip _____

New Address _____

City _____ State _____ Zip _____

CLINICAL UPDATE PULMONARY MEDICINE

December 7, 1988

COURSE DESCRIPTION:

The 5th Annual Clinical Update is designed to provide family practitioners, general internists, pulmonologists and other interested physicians with an updated review of pulmonary disorders which are commonly encountered in clinical practice as well as certain disorders which are of current topical interest. The program has been carefully selected to ensure a good blend of established and new methods and approaches to pulmonary diseases.

The morning session will provide participants with systematic approaches to chest x-ray interpretation, pleural effusion, atypical pneumonias (*Legionella*, *Mycoplasma*, *Chlamydia*, viral, fungal) and pulmonary disorders produced by cardiovascular disease.

The afternoon session will present current concepts in the diagnosis and management of idiopathic pulmonary fibrosis and lung cancer. A special lecture will focus on the current status of lung transplantation for end-stage pulmonary disease. This session will conclude with a discussion of the pulmonary assessment and management of the surgical patient with lung disease.

Throughout the day, emphasis will be placed on risk factors, natural history, early detection, prognosis, newer diagnostic techniques and new methods of therapy.

A.M. MORNING SESSION

- 8:00 Registration
- 8:50 Welcome—*Vladir Maranhao, M.D.*
- 9:00 A Practical Guide to Chest X-Ray Interpretation
Wallace T. Miller, M.D.
- 9:50 Differential Diagnosis of Pleural Effusions
Steven A. Sahn, M.D.
- 10:40 Coffee Break
- 10:55 Pulmonary Disorders Produced by Cardiac Disease
David M.F. Murphy, M.D.
- 11:45 The Spectrum of Atypical Pneumonias
Steven A. Sahn, M.D.

P.M. AFTERNOON SESSION

- 12:30 Luncheon
- 1:30 Clara Falk Franks Lecture—Clinical Decisions in Idiopathic Pulmonary Fibrosis
J.A. Peter Paré, M.D.
- 2:20 Lung Transplantation for End-Stage Pulmonary Disease
Joel D. Cooper, M.D.
- 3:10 Coffee Break
- 3:25 Lung Cancer in 1988—Staging and Expectations of Surgery
Joel D. Cooper, M.D.
- 4:15 Reducing the Risk of Postoperative Pulmonary Complications
Mervyn Feierstein, M.D.
- 5:00 Adjourn

GUEST FACULTY

JOEL D. COOPER, M.D., Professor of Surgery and Chief, Section of Thoracic Surgery, Washington University School of Medicine, St. Louis, Missouri

WALLACE T. MILLER, M.D., Professor and Vice Chairman, Department of Radiology, Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania

J.A. PETER PARÉ, M.D., Professor Emeritus of Medicine, McGill University School of Medicine, Royal Victoria Hospital, Montreal, Quebec, Canada

STEVEN A. SAHN, M.D., Professor of Medicine and Director, Division of Pulmonary and Critical Care Medicine, Medical University of South Carolina, Charleston, South Carolina

LOCAL FACULTY

MERVYN FEIERSTEIN, M.D., Program Director, Attending Pulmonologist, Department of Pulmonary Medicine, Deborah Heart and Lung Center

VLADIR MARANHÃO, M.D., Clinical Associate Professor of Medicine, UMDNJ-Robert Wood Johnson Medical School, New Brunswick, New Jersey; Chairman, Department of Cardiology and Vice President of Medical Affairs, Deborah Heart and Lung Center

DAVID M.F. MURPHY, M.D., Program Chairman, Chairman, Department of Pulmonary Medicine, Deborah Heart and Lung Center

FIFTH ANNUAL CLINICAL UPDATE IN PULMONARY MEDICINE

Sponsored by:

Deborah Heart and Lung Center
Browns Mills, New Jersey
(609) 893-6611

Wednesday, December 7, 1988

NAME _____

ADDRESS _____

CITY/STATE _____ ZIP _____

SPECIALTY _____ PHONE (____) _____

Tuition: All participants, fee includes luncheon and refreshments—\$80.00.

A check in the amount of \$80.00 payable to Deborah Heart and Lung Center should accompany this application. Mail to Pulmonary Department, Deborah Heart and Lung Center, Browns Mills, N.J. 08015.

Due to limited seating capacity, early registration is strongly advised. Registration deadline—Wednesday, November 23, 1988.

Accreditation: Deborah Heart and Lung Center designates that this continuing education offering meets the criteria for 6.5 credit hours in category 1 of the Physician's Recognition Award of the American Medical Association.

This program has been reviewed and is acceptable for 6.5 prescribed hours by the American Academy of Family Physicians.

For Program Information please call: Mrs. Diane Colby (609) 893-6611.

(Somerset Medical Center)

- 7 **Annual Clinical Abstract Meeting**
1:30-5 P.M.—The Manor,
West Orange
(Oncology Society of New Jersey)
- 22 **Tumor Board Conferences**
12 noon-1 P.M.—Newcomb Medical
Center, Vineland
(Newcomb Medical Center)

PATHOLOGY

November

- 19 **Orthopaedic Pathology with
Emphasis on Nonneoplastic
Lesions**
9 A.M.-12 noon—Robert Wood
Johnson Medical School,
Piscataway
(NJ Society of Pathologists)

PSYCHIATRY

November

- 1 **Divorce and Custody: Impact on
Children and Parents**
8:30-9:30 A.M.—Newark Beth Israel
Medical Center, Newark
(Newark Beth Israel Medical
Center)
- 2 **Case Seminars To Improve**
- 16 **Psychotherapeutic Technique**
8-10 P.M.—2 West Northfield Road,
Livingston
(Advanced Psychiatric Study
Group)
- 3 **Indications for Family Therapy**
12 noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)
- 4 **Psychiatric Lecture Series**
- 18 **1:30-3:30 P.M.—Trenton Psychiatric
Hospital, Trenton**
(Trenton Psychiatric Hospital)
- 10 **Supportive Psychotherapy**
12 noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)
- 16 **AIDS: The Brain on Fire**
9 A.M.-5 P.M.—Carrier Foundation,
Belle Mead
(Carrier Foundation)
- 16 **Soul Murder: The Effects of Subtly
Expressed Child Abuse and
Deprivation Upon Emotional
Development**
7:30-10 P.M.—South Orange Middle
School, South Orange
(The Mental Health Association of
Essex County)
- 17 **Family Therapy with Adolescents**
12 noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)
- 17 **Psychoanalytic Concepts of the
Development Phase Specificity of
the Etiology of Severe Mental
Illness**
8-10 P.M.—Saint Barnabas Medical
Center, Livingston
(NJ Psychoanalytic Society)

December

- 1 **Grief Reactions and Linking
Objects**
12 noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)

- 2 **Psychiatric Lecture Series**
- 9 **1:30-3:30 P.M.—Trenton Psychiatric
Hospital, Trenton**
(Trenton Psychiatric Hospital)
- 7 **Early Office Recognition of
Depression**
1:30-2:30 P.M.—Essex County
Hospital Center, Cedar Grove
(AMNJ)
- 7 **Case Seminars To Improve**
- 14 **Psychotherapeutic Technique**
8-10 P.M.—2 West Northfield Drive,
Livingston
(Advanced Psychiatric Study
Group)
- 8 **Psychodynamic Observations on
Fathering**
12 noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)
- 14 **How To Heal a Broken Heart**
6:15-9 P.M.—Perona Farms, Rt. 517,
Andover
(Hackettstown Community
Hospital)
- 15 **Issues in the Treatment of
Adolescents**
12 noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)

PULMONARY

November

- 1 **Pulmonary Conferences**
- 8 **8-9 A.M.—New Jersey Medical
School, H-349, Newark**
(UMDNJ)
- 22
- 29
- 1 **Pulmonary Case Conferences**
- 8 **8-9 A.M.—University Hospital,
New Brunswick**
(UMDNJ)
- 22
- 29

December

- 6 **Pulmonary Conferences**
- 13 **8-9 A.M.—New Jersey Medical
School, H-349, Newark**
(UMDNJ)
- 20
- 27
- 6 **Pulmonary Conferences**
- 13 **8-9 A.M.—University Hospital,
New Brunswick**
(UMDNJ)
- 20
- 27
- 7 **5th Annual Clinical Update in
Pulmonary Medicine**
8:00 A.M.-5 P.M.—Deborah Heart and
Lung Center, Browns Mills
(Deborah Heart and Lung Center)

RADIOLOGY

November

- 10 **Radiological Society of
New Jersey Meeting**
7:30-9:30 P.M.—Saint Barnabas
Medical Center, Livingston
(Radiological Society of NJ and
AMNJ)
- 30 **Dinner Meeting**
6:30-9:30 P.M.—The Manor,
West Orange
(Radiation Oncology
Section—AMNJ)

December

- 15 **Radiological Society of
New Jersey Meeting**
7:30-9:30 P.M.—Saint Barnabas

Medical Center, Livingston
(Radiological Society of NJ and
AMNJ)

SURGERY AND SURGICAL SPECIALTIES

November

- 1 **Surgical Grand Rounds**
- 15 **7-9 A.M.—Hackensack Medical
Center, Hackensack**
(Hackensack Medical Center)
- 22
- 29
- 2 **Developments of Microvascular
Surgery**
6:30-10:30 P.M.—The Manor,
West Orange
(Vascular Society of New Jersey)
- 21 **Surgical Series**
8-9 A.M.—West Hudson Hospital,
Kearny
(West Hudson Hospital)
- 22 **Update on the Management of
Surgical Infections**
8-10 P.M.—Englewood Club,
Englewood
(Englewood Surgical Society)

December

- 2 **Surgical Management of Benign
and Malignant Disease of the
Breast**
7:30-8:30 A.M.—Freehold Area
Hospital, Freehold
(AMNJ)
- 3 **37th Annual Clinical Meeting**
8:30 A.M.-4:30 P.M.—Berkeley
Carteret Hotel, Asbury Park
(New Jersey Chapter, American
College of Surgeons)
- 6 **Surgical Grand Rounds**
- 13 **7-9 A.M.—Hackensack Medical
Center, Hackensack**
(Hackensack Medical Center)
- 20
- 21 **Surgery—Alternatives to
Ileostomy and Colostomy**
10:30-11:30 A.M.—St. Mary's
Hospital, Passaic
(AMNJ)

UROLOGY

November

- 3 **Extracorporeal Shock Wave
Lithotripsy**
11-12 noon—St. Joseph's Hospital
and Medical Center
(St. Joseph's Hospital and Medical
Center)
- 9 **Urology Rounds**
6:20-8:30 P.M.—Robert Wood
Johnson Medical School, 108B,
New Brunswick
(UMDNJ)
- 10 **Urology-TUR**
10:30-11:30 A.M.—St. Mary's
Hospital, Passaic
(AMNJ)
- 16 **Evaluation and Management of
Kidney Stones**
1:30-2:30 P.M.—HMO,
New Brunswick
(Rutgers Community Health Plan)

December

- 14 **Urology Rounds**
6:20-8:30 P.M.—Robert Wood
Johnson Medical School, 108B,
New Brunswick
(UMDNJ)

CANCER PAIN

The Second in the Ongoing Series
on Multidisciplinary Management
of the Patient with Cancer.

Dec. 8th and 9th.

SURGICAL ONCOLOGY II

The second "Multidisciplinary Management of the Patient with Cancer" seminar at Fox Chase Cancer Center is a review of advances in and techniques of pain management for cancer patients. National experts will conduct lectures and workshops focusing on the interdisciplinary management of cancer pain, with opportunities for active exchange of knowledge.

For more information and reservations, please call Kathy Smith at 215-728-2715.

FOX CHASE
CANCER CENTER
7701 Burholme Avenue Phila., PA 19111

As an organization accredited by the Accreditation Council for Continuing Medical Education, Temple University School of Medicine certifies that this program meets the criteria for 9.5 credit hours of Category I, provided it is completed as designed.

LETTER TO THE EDITOR

Medicare Participation

Dear Doctor Slobodien:

The Medicare program, since its inception, has posed the threat of socialized medicine.

The gross miscalculation of the original cost projections was inexcusable. There is a temptation to charge it off to stupidity, but politicians, whatever else they might be, are rarely stupid.

The scenario, which now should be retrospectively clear, was to buy votes with lavish promises, and then find scapegoats upon whom to blame the failure.

The stated assurance of noninterference into the doctor-patient relationship was disavowed once the

program was established.

Long before Alzheimer's became fashionable, time was taking its toll on memory. Too few people remember that Medicare was to have been a "supplemental" health insurance. Along the way, it has been converted, at least in rhetoric, to an entitlement.

Present participation constitutes "welfare for the wealthy."

Our time-honored tradition of treating the truly needy at low or no cost still exists to a large degree. Most doctors accept what Medicare is willing to pay in selected cases. Usually, all that is necessary is for the patient to ask. In the current competitive atmosphere, even those lacking our customary compassion are likely to comply.

What was left of the voluntary free-choice elements of Medicare permitted ample latitude for resolving the problems of the needy on an individual basis. Organized medicine either has been unwilling or unable to get these simple facts to the general public. Refusal by all physicians to abandon the long-standing process of billing fair fees, and making appropriate adjustments where indicated would have scuttled this whole scheme. Those entrepreneurs, who chose to practice wholesale, cut-rate medicine could have taken an ad in the local paper. Ironically, they probably are the same individuals who have tarnished our image by exploiting the system, and likely are nonmembers of our organizations.

This whole push for participation has been a coercive effort to alter public perception, and stampede physicians into involuntary servitude. There has been no attempt to hide the plan, once voluntary par-

ticipation reaches an adequate level, to make compliance mandatory. If there is any doubt, let me offer our New Jersey DRG experience as a vivid example of that *modus operandi*.

My personal policy of dealing directly with the patient has had some obvious and some subtle benefits. It has spared me the cost and frustration of dealing with the computerized bureaucracy. My patients have learned first-hand about the trials and tribulations of dealing with their benevolent benefactors.

The "participation scam" should be attacked on several grounds:

First, the publication of participant lists gives the false impression that nonparticipants will not treat, or will charge excessive fees to Medicare patients.

Second, differential payments, which penalize nonparticipants, represent a further unfairness, above and beyond the grossly discriminatory mandatory fee freezes of the past few years.

Last, but not least, the Massachusetts preview of things to come should provide sufficient incentive for resistance.

We have become the victims of a succession of bad ideas. Rather than offering outright opposition, the AMA repeatedly has chosen to maintain a conciliatory position. Negotiated minor concessions, at best, have delayed slightly the eventual devastating impact upon our lives and our livelihood.

Coupled with private sector third-party activities, the box that we are in has been pretty neatly wrapped. We had better take some definitive action, before the bow is affixed for presentation to Big Brother!

(signed) Frank J. Primich, M.D.

Gynecologic Surgery; The Hand; Mycobacterium tuberculosis: Interactions with the Immune System

Gynecologic Surgery

Luis E. Sanz, M.D., (ed). Oradell, NJ, Medical Economics Books, 1988. Pp. 451.

Gynecologic Surgery is written clearly, is well illustrated, and describes concisely many current gynecologic operative techniques. Chapters cover general, vaginal, and urologic surgery, as well as some newer laparoscopic and laser techniques. A particularly valuable section includes detailed surgical methods of managing complications of gynecologic surgery such as bladder and bowel injuries.

Tight editorial control has eliminated most of the duplication that can be found in some multi-authored texts. The contributors all give generously of their expertise in providing useful information, not only by a clear description of the operative procedure; but also in providing information on specific suture material and equipment setting, where appropriate. The reader more easily then may duplicate their techniques.

This book is recommended for pelvic surgeons and may be especially useful to gynecologists who wish to review or learn the latest techniques in their specialty.

Gerard F. Hansen, M.D., M.P.H.

The Hand, Volume III

Raoul Tubiana, M.D., (ed). Philadelphia, PA, W.B. Saunders Co., 1988. Illustrated. Pp. 1,296.

This is the third of four volumes entitled, *The Hand*; it is edited by Dr. Tubiana, renowned hand surgeon of the Hand Institute in Paris. Volume I was published in 1981 and deals with anatomy and basic sciences; Volume II appeared in 1985, and Volume IV has yet to be released. Volume III deals with trauma to tendons, nerves, and blood vessels; as well as thermal injuries, bite wounds, and amputations.

There are 110 contributors of international repute; of the 114 chapters, nearly a third are written by Dr. Tubiana. Like most multi-authored textbooks, the same subject may be discussed by different authors independently of the others, leaving the reader at the mercy of the index which, while fairly complete, causes a great deal of finger-walking. The table of contents is excellent, however. Oddly, footnote references are made to as-yet-unreleased Volume IV. Neither the table of contents nor the index lists materials in the earlier volumes—a serious flaw.

This is a comprehensive surgical reference work intended for surgeons with a major interest in the hand; it is not for students or for residents. The illustrations are mostly black-and-white. The drawings are excellent, but the photographs are not. Some are silly for an advanced surgical text, such as one showing the harvesting of palmaris longus for tendon grafting. Many others are too dark to show anatomic detail. There are only eight color plates in the book.

Some of the material is outdated. The chapter on recent advances in peripheral nerve surgery cites not one reference earlier than 1983. Reflex sympathetic dystrophy (RSD) is called only by its obsolete name, causalgia (coined in 1864), and it is discussed under war injuries. The latest reference is 1978 despite significant advances in RSD.

Although there is much good material in this book, it suffers from fragmentation and obsolescence. It already has taken the better part of the decade to publish.

Richard M. Ball, M.D.

Mycobacterium tuberculosis: Interactions with the Immune System

Mauro Benine-li and Herman Friedman, (eds). New York, NY, Plenum Press, 1988.

This is the second book in the series entitled, *Infectious Agents and Pathogenesis*. Studies on the mechanisms of disease caused by infectious agents require an expansive knowledge of many areas, especially immunology, as well as integrating experiments of basic science and clinical research.

The text is directed mainly towards individuals requiring more indepth knowledge of tuberculosis.

Robert Koch's discovery, that tuberculosis was caused by an infectious agent, revolutionized our thinking about diseases. Koch's postulates actually developed with tuberculosis in mind and became a focal point for many advances in microbiology and medicine. According to the World Health Organization, there are at least 30 million individuals in the world today that are affected by tuberculosis and as many as 1 million die as a result of it every year. Although this disease is a major public health problem in developing countries, there has been recent concern that the disease might once again manifest itself with renewed virulence in more developed countries, such as the United States, due to the spread of the human immunodeficiency virus causing AIDS.

This text is highly recommended for all individuals wishing to pursue more indepth study of this fascinating organism. The text is well organized, starting with the more mundane characteristics of mycobacterial diseases; the book reveals many areas that require further analyses. The editors and authors of this volume have organized the burgeoning information that presently is available on *M. tuberculosis* and its interaction with the immune system. The text provides an environment for interdisciplinary studies of this extremely important area of investigation. As stated by the editors, "Few infections, if any, illustrate the complexity and the double-edged nature of immune responses as effectively as tuberculosis." Leonard Bielory, M.D.

**Drs. Fox; Holland;
O'Grady; Pessah; Stekler;
Tschekunow; Willan;
Woodward**

Dr. Irving R. Fox

Irving R. Fox, M.D., a pediatrician in Union for 36 years, and founder of the Union Pediatric Medical Group, died on June 21, 1988, at the age of 64. A Paterson native, Dr. Fox received his medical degree from the New York University School of Medicine, in 1947. A diplomate in pediatrics, Dr. Fox was an affiliate of Newark Beth Israel Medical Center; Elizabeth General Medical Center, as chief of pediatrics; St. Elizabeth Hospital, Elizabeth; and Saint Barnabas Medical Center, Livingston. During World War II, Dr. Fox served with the United States Navy, and he was a U.S. Air Force captain in the Korean Conflict. Dr. Fox was a member of our Union County component and of the American Medical Association.

Dr. Albert H. Holland

Retired Morristown physician Albert Harold Holland, Jr., M.D., died on June 13, 1988, at the age of 69. A Morristown native, Dr. Holland received his medical degree at New York University School of Medicine, in 1944. In addition to private practice in Morristown, Dr. Holland was a lecturer for the Department of Nutrition and Metabolism, Northwestern University, Chicago, from 1955 to 1958. He served with the

U.S. Army as lieutenant from 1946 to 1947, and with the U.S. Public Health Service from 1954 to 1958. Dr. Holland was a member of our Morris County component and of the AMA.

Dr. Michael J. O'Grady

Retired since 1986 from surgery practice, Michael James O'Grady, M.D., 78, died on March 19, 1988. Born in Newark, Dr. O'Grady received his medical degree at Georgetown University School of Medicine, Washington, D.C., in 1933. As well as maintaining a Belleville office, Dr. O'Grady was affiliated with Clara Maass Medical Center, Belleville; Saint Barnabas Medical Center, Livingston; and The Mountainside Hospital, Montclair. A member of our Essex County component and of the AMA, Dr. O'Grady was a fellow of the American and International Colleges of Surgeons, and of the New Jersey College of Colon-Rectal Surgery. He was a lieutenant commander in the U.S. Navy during World War II. In 1983, Dr. O'Grady received the Golden Merit Award.

Dr. Joseph L. Pessah

Internal medicine specialist Joseph Leo Pessah, M.D., 54, died on May 5, 1988. A native of Tuzla, Yugoslavia, Dr. Pessah received his medical degree from Belgrade University Medical School, Yugoslavia, in 1964. After emigrating to the United States and establishing a private practice, Dr. Pessah became affiliated with The Mountainside Hospital and Montclair Community Hospital, both in Montclair. He was a member of our Essex County component and of the AMA.

Dr. Burton L. Stekler

Pediatrician Burton Lester Stekler, M.D., 63, died on June 19, 1988. A Brooklyn, New York, native, Dr. Stekler received his medical degree from New York University School of Medicine, in 1950. A diplomate in pediatrics and a fellow of the American Academy of Pediatrics, Dr. Stekler was affiliated with The Valley Hospital, Ridgewood, helping to establish its Drug Center. He was instrumental in starting the Glen Rock Blood Bank and was physician for the Glen Rock High School. From 1953 to 1955, Dr. Stekler served with the U.S. Army as

first lieutenant. Dr. Stekler was a member of our Bergen County component and of the AMA.

Dr. Alexej Tschekunow

Retired pathologist and former Sussex County medical examiner Alexej Tschekunow, M.D., 64, died on May 21, 1988. Born in the Russian Ukraine, Dr. Tschekunow received his medical degree from the University of Munich, Germany, in 1953. With the aid of the International Rescue Group, Dr. Tschekunow emigrated to the United States in 1955, settling in Long Branch. He became affiliated with several hospitals, including Wallkill Valley General Hospital, Sussex, where he was chief pathologist and laboratory director from 1967 until his retirement in 1985. Dr. Tschekunow was medical examiner for Sussex County from 1968 until 1985. He was a member of our Sussex County component, of the National Association of Medical Examiners, and of the AMA.

Dr. Edward H. Willan

Retired general surgeon Edward Hallick Willan, M.D., died on May 31, 1988, at the age of 93. He attended New York Medical College, where he received his medical degree, in 1916. In addition to an East Orange private practice, Dr. Willan maintained an affiliation with East Orange General Hospital for over 40 years, where he was president of the staff for 14 years, member of the Board of Trustees, head of the Surgical Department, and instructor of surgical nursing. A fellow of the American College of Surgeons, Dr. Willan was a member of our Essex County component and of the AMA. During World War I, he was a captain in the U.S. Army medical corps. In 1966, he received the Golden Merit Award.

Dr. William J. Woodward

Internal medicine specialist William John Woodward, M.D., 66, died on June 15, 1988, after 35 years as a physician in Asbury Park. Born in Atlantic Highlands, Dr. Woodward received his medical degree from Jefferson Medical College of Philadelphia, Pennsylvania, in 1947. A diplomate in internal medicine and a fellow of the American College of Physicians, Dr. Woodward was a member of our Monmouth County component and of the AMA.

AUTHOR INFORMATION

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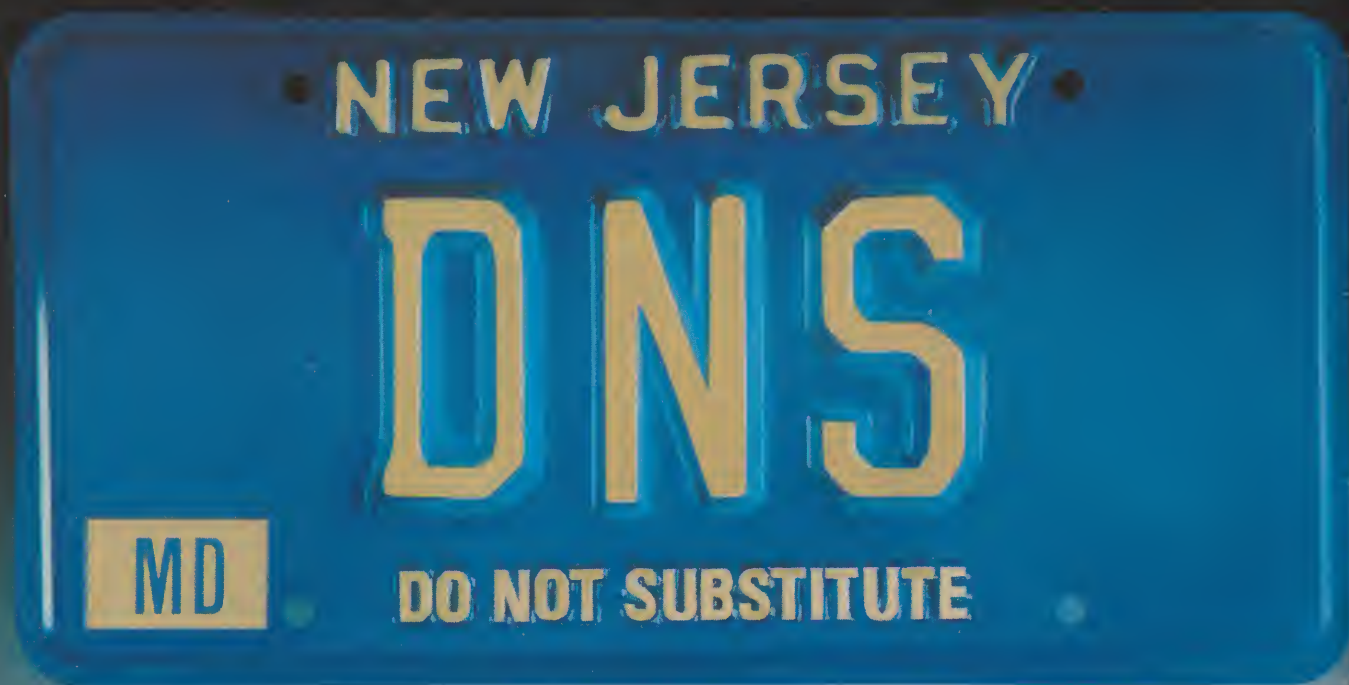


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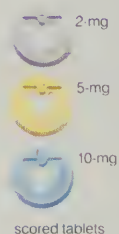
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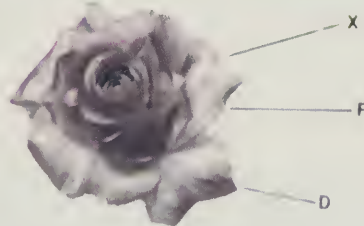
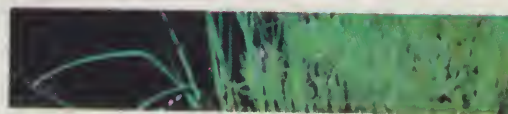
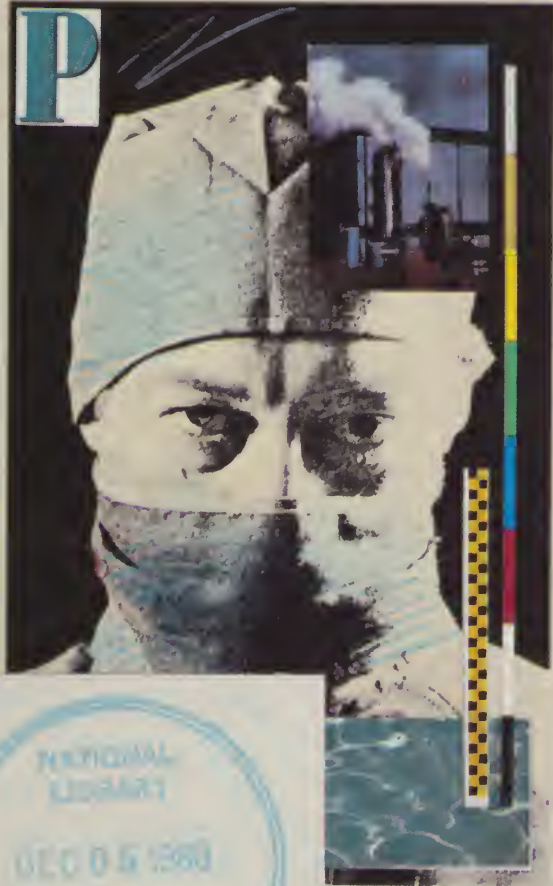
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DALE L. TIPTON, M.D.

Associate Clinical Professor, Department of Otolaryngology, Head and Neck Surgery, University of California School of Medicine, San Francisco, California.

Chairman, Division of Otolaryngology, Franklin Hospital, San Francisco, California.

Lieutenant Colonel, U.S. Army Reserve.

EDUCATION University of California at Berkeley, A.B. Physiology; University of California School of Medicine, San Francisco, M.D. and Master of Science, Pharmacology.

RESIDENCY University of California School of Medicine, San Francisco: General Surgery — 2 years; Otolaryngology — 3 years.

FELLOWSHIPS National Institute of Health Fellow; Cancer Research Institute, University of California, San Francisco.

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NOVEMBER 1988

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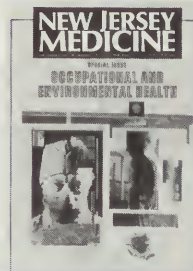
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On The Cover: Our special issue covers the environmental and occupational health of New Jersey, beginning on page 892. Cover: Will Harmuth.





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BRIEF SUMMARY

CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate.

PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

Pregnancy: Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

OVERDOSAGE

There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

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Issued 1/87

Reference:

1. Eliakim R, Ophir M, Rachmilewitz D: *J Clin Gastroenterol* 1987;9(4):395-399.

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Physician Procedures

Plastic Surgeon Publishes Photographs of Patient; School Physician Not Liable for Evaluation of Student; Court Increases Claimants' Rights; Wrongful-Death Recovery is Denied

PLASTIC SURGEON PUBLISHES PHOTOGRAPHS OF PATIENT RESULTING IN \$10,000 VERDICT

An action was brought against the defendant plastic surgeon who performed cosmetic surgery on a 19-year-old female plaintiff's face to correct a protrusion on her nose. Seven years following the procedure, the defendant physician showed "before and after" facial photographs of the plaintiff on a cable television program. The plaintiff alleged that the defendant breached his duty to maintain the physician/patient confidentiality in publishing the photographs without her consent.

The defendant countered that the plaintiff consented to have the photographs utilized by the defendant for teaching and educational purposes, and in support of this assertion, offered a written consent form signed by the plaintiff at the time of treatment authorizing such use.

The plaintiff contended that the consent form offered into evidence by the defendant did not contemplate the use of the pictures on a public television station broadcast to more than one million homes, and offered the expert testimony of a professor of medical ethics to support this assertion.

On cross-examination, the defendant physician admitted in retrospect, he should have obtained a more specific consent for this type of use.

The plaintiff alleged that she suffered a post-traumatic stress disorder as a result of the publication, as testified to by an expert examining psychiatrist. Specifically, this expert related that the manifestations of the disorder are depression, shame, and anger, which would necessitate management with medication.

The defendant offered countering expert testimony from an examining psychiatrist who maintained that the plaintiff was a young, healthy woman who had not sustained any psychiatric residual as a result of the subject incident.

The court directed a verdict in favor of the plaintiff on the issue of liability at the close of all the evidence. The jury returned a verdict of \$10,000. (*New Jersey Verdict Review and Analysis*, Volume 9, Issue 3, July 1988)

SCHOOL PHYSICIAN NOT LIABLE FOR EVALUATION OF STUDENT

A school physician who found that a junior high school student was not physiologically mature enough for a senior high school tennis team was not liable for medical malpractice or for negligent infliction of emotional distress, a New York appellate court ruled.

Local boards of education could permit junior high school students to compete on senior high school teams, provided they were placed at levels of competition appropriate to their physiological maturity. The level of maturity was to be determined by the school physician according to guidelines established by the New York State Education Department.

The physician, using the recommended screening procedures, found that the student was not sufficiently mature to try out for the tennis team. The student brought an action against the physician and the school district. He alleged that he had been subjected to great humiliation, embarrassment, and scorn, and had suffered mental and physical distress. He contended that the physician had negligently failed to exercise reasonable judgment and had failed to follow proper medical practice in evaluating his level of physiological maturity.

The physician and the district moved for summary judgment on the grounds that the complaint failed to state a cause of action. The trial court denied the motions, stating that there were factual issues in this case.

On appeal, the student contended that he had a cause of action for negligent infliction of emotional distress and medical malpractice. The court said the complaint alleged that, because of an incorrect determination of the student's maturity, he was improperly excluded from trying out for the team. The court said that this amounted to educational malpractice, which was not recognized in the courts of the state.

As far as the complaint alleged a cause of action for medical malpractice, the court said that the physician owed the student no duty other than to administer the screening test properly. Since there was no allegation that this was not done, the court said that the physician had not breached the duty. The court reversed the lower court's judgment. (Reprinted from *The Citation* with permission, American Medical Association, 535 N. Dearborn Street, Chicago, IL 60610, May 1, 1988, Volume 57, No. 2)

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are Director of the Department and Director of Special Projects, respectively.

COURT INCREASES CLAIMANTS' RIGHTS IN MALPRACTICE

The New Jersey State Supreme Court has ruled that even if a patient is partially to blame for an illness or complication, she still may recover damages in a malpractice case.

The legal dispute centered on the health problems of a woman who was a diabetic and lost her leg when gangrene set in after minor surgery was performed to remove part of a problem toenail.

The jury found that while the defendant physician acted negligently by removing the toenail without adequately considering the plaintiff's other serious health problems, the patient was more at fault for maintaining poor health practices.

Evidence was presented at the trial that during the period before the surgery, the plaintiff did not follow the physician's instructions to quit smoking, or to maintain her weight, blood sugar, and diet at acceptable levels.

The jury found that the plaintiff was 51 percent at fault, while the physician was 49 percent at fault, and therefore she was not entitled to receive any damages.

Under New Jersey law, a victim who is more than 50 percent responsible for an injury is ineligible to receive damages.

However, the Supreme Court ruled such a blanket denial of damages to patients who may be largely at fault for their own complications is unfair. (*The Times*, August 12, 1988)

WRONGFUL-DEATH RECOVERY IS DENIED

Parents may not recover wrongful-death damages when a child is stillborn, the New Jersey Supreme Court ruled recently in the case of a New Providence couple.

The court, in a 6-0 decision, fell back on a long-standing definition of a fetus as being part of its mother and not a separate person, and ruled an unborn child does not have the same legal rights as one that is born alive.

Statute and precedent suggest that "the traditional definition of 'person' under the (wrongful-death) act

be retained," Justice Alan B. Handler wrote for the court. "We are persuaded ultimately because we find no compelling underlying policy that would impel us to give the statutory term 'person' an expansive interpretation."

Lawyers for the defendant physician had argued that a decision for the couple would open a floodgate of wrongful-death lawsuits by parents of "viable" fetuses. Those who support abortion also said a wrongful-death ruling could have armed abortion foes in their battle for legal recognition of fetuses.

The high court ruled that parents are entitled to sue only for their own mental distress and suffering.

In oral arguments before the court last May, the plaintiff's attorney said he and the couple wanted "to have the fetus recognized as a person."

He said the parents wanted the law expanded so parents who lose a child before birth could sue for the same kind of damages that parents of a living child could.

The couple sued in 1985, two years after their baby was stillborn. They claimed the physician erred by refusing to perform a caesarean section with the birth more than two weeks overdue and the mother experiencing intermittent pain and contractions.

Their suit sought damages for the infant's "conscious pain and suffering," but asked for no compensation on behalf of the plaintiffs themselves.

The case was dismissed a year later, and the Appellate Division of Superior Court affirmed the dismissal.

The defendant's attorney said a ruling for the couple would have opened a Pandora's box for judges and medical specialists. Among other difficult issues, he said it would leave courts to determine at what point a fetus becomes a separate person and whether one's death is due to trauma, like a car accident, or to biological causes.

Wrongful-death suits on behalf of fetuses have not been allowed in New Jersey since 1964, when the Supreme Court ruled against a pregnant woman who lost her fetus in an automobile accident. (*The Times*, August 11, 1988)

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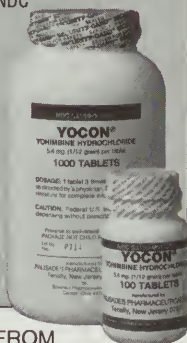
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2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
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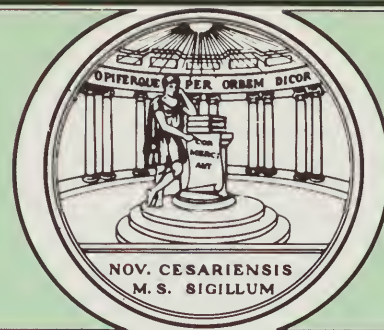
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MEMBERSHIP NEWSLETTER



MSNJ

THE MEDICAL SOCIETY OF NEW JERSEY

Volume 60

MSNJ COMMITTEE ON UTILIZATION REVIEW SYSTEMS Review Certification

Insurance companies have become more and more aggressive in their precertification and concurrent review policies. In order to ascertain the status, Robert J. Weierman, M.D., chairman of the Committee on Utilization Review Systems, contacted the Departments of Health and Insurance to determine just who—besides our regular PRO/URO contractors—are able to do this. He noted that the Department of Insurance, state of New Jersey, has approved five insurance companies to do preadmission and concurrent review certification: Prudential Insurance Company, New Jersey Blue Cross, Provident Life and Accident, Connecticut General Life Insurance Company, and Home Life Insurance Company.

All other approvals for New Jersey-based companies have been on hold since July 1985, when the Department of Insurance imposed a moratorium. These companies are approved to do review for purposes of payment by the insurance company. The five certified UROs currently in the state of New Jersey perform reviews for purposes of hospital billing. A problem does occur when the insurance carrier refuses to recognize the certified URO or delegated hospital determination.

In essence, two avenues of approach can be taken. One would be to send a letter to the nonapproved insurance company which is attempting to get concurrent information; this would be on your letterhead. Suggested format follows:

Re: Patient's Name
Hospital: Hospital Name
Admission: Date
Contract: Number (if relevant)

Attached for your information is a copy of the New Jersey Department of Health memorandum of July 1987, which states in part: "It is the policy of the Department of Health that, for purposes of acute care hospital reimbursement, only the State Certified Utilization Review Organizations (UROs) have binding authority in utilization review determinations, i.e. length of stay and medical necessity denials."

We have been informed that an unofficial review of the above-mentioned patient's hospitalization

has been conducted. This unofficial review generally has no effect on the bill; however, this hospitalization has been reviewed and legally certified by the URO.

To sustain the integrity of New Jersey's cost-containment program, employers and/or insurers are urged to contract directly with a certified URO for all review services in New Jersey for any additional review, monitoring, or date of services that are of interest. Inquiries regarding URO certification can be forwarded to the New Jersey Department of Health. We request that you direct all other questions and requests concerning utilization review matters to the URO.

Sincerely yours,

Copies to: New Jersey Department of Health
John Fitch Plaza, CN-360
Trenton, New Jersey 08625
New Jersey Department of Insurance
201 East State Street, CN-325
Trenton, New Jersey 08625

Another alternative would be to send a copy of the New Jersey Department of Health memorandum calling attention to the third paragraph which states: "Hospitals are encouraged and may (but are not obligated to) provide utilization information to payor or payor agents." This could be sent to the insurance company with a request to contact Bernice Ferguson, 609/292-0086.

HEART, LUNG, AND BLOOD INSTITUTE Hypertension

The 1988 Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure is available from the National Heart, Lung, and Blood Institute (NHLBI). The report was released by the coordinating committee of the National High Blood Pressure Education Program, a program sponsored by the NHLBI. This represents the fourth in a series of reports which have provided physicians and other health professionals with updated therapy recommendations for more than a decade.

This report reviews, updates, and expands the 1984 recommendations for controlling hypertension. The new report translates the results of the latest clinical trials to medical practice; addresses the needs of

PRESIDENT'S HOT-LINE

Palma E. Formica, M.D.

★ **Special Assessment.** I have received a number of letters from members who are opposed to the \$100 special assessment mandated by the House of Delegates to fund special public relations activities. We can grant exemptions for financial hardship. We cannot grant exemptions to conscientious objectors.

★ **Nursing Shortage.** The nursing and technician shortage is a concern for all physicians. In order to enhance our communication with nurses, the Board of Trustees has extended an invitation to the president and executive director of the New Jersey State Nurses Association to attend our meetings.

★ **Licensing Reform Legislation.** Senator Codey has introduced a legislative proposal to amend and to improve the physician licensing system in New Jersey. While the Senator initiated this project as a result of the SCI report on impairment, we believe a fair and effective program will develop through the efforts of the Society and Judge Herbert J. Stern.

★ **Malpractice Reinsurance Surcharge.** The insurance commissioner has filed a proposed regulation

that places a 6 percent surcharge on the malpractice policies of all physicians for the next seven years. The surcharge is intended to offset a \$45 million deficit caused by 3,500 physicians and podiatrists insured by the Reinsurance Association from 1977 through 1982. Those individuals made conscious and voluntary choices to insure with the state. They did not purchase subordinated loan certificates and actually paid lower rates. The Society does not accept the commissioner's position that insureds other than those directly involved should pay the surcharge.

★ **Consultants to the SBME.** The Board has agreed to develop a list of experts to assist in peer review for the State Board of Medical Examiners.

★ **Physical Therapy Regulation.** The State Board of Medical Examiners has proposed a regulation to prevent physicians from employing physical therapists or having an interest in a physical therapy practice. The Society has filed comments in opposition, and will vigorously oppose adoption of this illegal and anti-competitive proposal.

special populations; examines factors that influence the cost of care; and provides additional guidelines for managing high blood pressure in the presence of cardiovascular diseases and other coexisting medical conditions. It is intended as a guide for practicing physicians and other health professionals in their care of hypertensive patients, and as a reference for those participating in the many community HBP control programs throughout the country.

A copy may be obtained free of charge by contacting: The National High Blood Pressure Education Program Information Center, 4733 Bethesda Avenue, Suite 530, Bethesda, MD 20814.

PHARMACEUTICAL MANUFACTURERS ASSOCIATION (PMA) Drug Samples

Physicians should know that their right to use and distribute drug samples to patients is in no way affected by the new Prescription Drug Marketing Act. Signed into law in April, the main thrust is to establish new requirements affecting the distribution and marketing of prescription drugs. Of specific interest to physicians are the provisions that ban the sale, trade, or purchase of drug samples and require manufacturers distributing pharmaceutical samples to follow certain storage, handling, and accounting procedures.

Criminal penalties were put into effect on July 22, 1988, for anyone who sells, trades, or purchases drug samples. The penalties can be as much as ten years in prison, and up to \$250,000.

The physician needs to keep in mind a few points about this new law:

1. The law does not prevent physicians from receiving or dispensing drug samples.

2. In order to receive samples, physicians are required to sign a written request form verifying the identity of the drug and the quantity requested. This part of the law becomes effective October 20, 1988.

This written request form is required by some states and already is commonly used by manufacturers.

3. Although the law does not require physicians to maintain inventory records, manufacturers may ask physicians for their help in assuring that they did receive the samples requested. While the new law does not mandate physicians to cooperate with this verification procedure, the law does encourage manufacturers to implement such a system.

The Pharmaceutical Manufacturers Association and the American Medical Association convinced Congress that the initial proposals to ban samples would hamper efforts to provide quality medical care.

Samples allow the physician to evaluate a specific drug to ensure the patient tolerates it and to determine if the drug has the desired effect. Samples also permit the physician to begin therapy immediately, which can be very important in some cases, especially in rural areas.

The legislation that was passed does not threaten the practice of sampling, but does help safeguard the integrity of prescription drugs distributed in this manner. Many of the procedural requirements imposed on manufacturers have long been established policies for PMA member companies.

Physicians and patients value drug samples, according to surveys, and believe the practice of sampling should continue. PMA and its member companies also believe in the value of sampling, and we will work to implement this new law smoothly so that samples can continue to play a useful role in patient care.

HEALTH, RESEARCH AND EDUCATION TRUST OF NEW JERSEY Adult Immunization Education

The Health, Research and Educational Trust of New Jersey at the Center for Health Affairs has received funding from the New Jersey State Department of Health for the expansion of its hospital-based im-

**County and Specialty Societies, The Academy of Medicine of New Jersey,
and MSNJ Auxiliary Attendance at Meetings of the Board of Trustees**

January 1988—June 1988

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April 27	Irving P. Ratner, M.D.	April 10	Charles J. Zwerling, M.D., President-Elect
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March 20	Angelo S. Agro, M.D. Ardith R. Lane, Executive Director	March 20	Stevan Adler, M.D., Secretary
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April 27	Joseph A. Riggs, M.D. Angelo S. Agro, M.D. Frederick W. Durham, M.D.	Ocean County	
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June 12	John S. Garra, M.D., Secretary	February 21	Nanette Stummer, Executive Director
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April 27	Arthur Bernstein, M.D. Arthur R. Ellenberger, Executive Secretary William Greifinger, M.D.	May 1	Nanette Stummer, Executive Director
May 1	Carolyn W. Watson, M.D.	Passaic County	
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February 21	Churchill L. Blakey, M.D.	April 27	Elmar G. Lutz, M.D., President
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April 10	Churchill L. Blakey, M.D.	June 12	Elmar G. Lutz, M.D., President
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February 21	Manuel A. Rivas, M.D.		
March 20	Manuel A. Rivas, M.D.		
April 10	Joey Huddy, Executive Secretary Manuel A. Rivas, M.D.		

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Irene Rosenthal,
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April 10 A. Ralph Kristeller, M.D.
April 27 A. Ralph Kristeller, M.D.
Andrea Maniscalco
Frank R. Romano, Sr., M.D.
Irene Rosenthal,
Executive Director
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A. Ralph Kristeller, M.D.
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June 12 A. Ralph Kristeller, M.D.
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February 21 Raymond S. Buch, M.D.,
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June 12 James H. Spillane, M.D.
James H. Spillane, M.D.

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May 1 M.H. Amir Zanjani, M.D.,
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New Jersey State Society of Anesthesiologists

January 17 Stanley Bresticker, M.D.
June 12 Stanley Bresticker, M.D.

New Jersey Chapter, American College of Emergency Physicians

January 17 Rudolf E. Schwaeble, M.D.
March 20 Rudolf E. Schwaeble, M.D.
April 10 Rudolf E. Schwaeble, M.D.
April 27 Rudolf E. Schwaeble, M.D.
June 12 Rudolf E. Schwaeble, M.D.

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President
March 20 Huerta C. Neals, M.D.,
President
April 10 Frank J. Malta, M.D.
June 12 Barry R. Zitomer, M.D.,
President

New Jersey Association of Medical Specialty Societies

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June 12 Stanley Bresticker, M.D.

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February 21 John D. Franzoni, M.D.
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March 20 John D. Franzoni, M.D.
Gilbert R. Sugarman, M.D.,
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April 10 John D. Franzoni, M.D.
June 12 John D. Franzoni, M.D.

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February 21 John S. Garra, M.D.,
Chairman
March 20 John S. Garra, M.D.,
Chairman
June 12 John S. Garra, M.D.,
Chairman

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April 10 Frank Campo, M.D.,
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April 27 Frank Campo, M.D.,
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May 1 Eva Muller, M.D.,
President-Elect
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New Jersey Rheumatism Association

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February 21 William E. Ryan, M.D.
April 10 William E. Ryan, M.D.
May 1 William E. Ryan, M.D.
June 12 William E. Ryan, M.D.

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President
March 20 Ames L. Filippone, Jr., M.D.,
President
April 10 Ames L. Filippone, Jr., M.D.,
President
June 12 Ames L. Filippone, Jr., M.D.,
President

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Urology Society of New Jersey

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Secretary-Treasurer

Academy of Medicine of New Jersey

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February 21 Charles J. Heitzmann,
Executive Director
March 20 Sherman Garrison, M.D.
April 10 Sherman Garrison, M.D.
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April 27 Sherman Garrison, M.D.
June 12 Charles J. Heitzmann,
Executive Director
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President
May 1 Mrs. Richard Lorber
Mrs. Joseph N. Micale
Mrs. Frank Campo,
President
June 12 Mrs. Frank Campo,
President

1989 MSNJ Annual Meeting

The Board of Trustees of the Medical Society of New Jersey at its September 18, 1988, meeting, approved the Committee on Annual Meeting recommendation that the 1989 Annual Meeting be held at the Sheraton Meadowlands Hotel in East Rutherford, on Thursday, April 27, through Sunday, April 30, 1989.

The daily schedule follows:

Wednesday, April 26, 1989

3:30 P.M. Board of Trustees' Meeting

Thursday, April 27, 1989

8:00 A.M. Registration Opens

8:00 A.M. Message Center Opens

10:00 A.M. House of Delegates

1:00 P.M. Program—Topic of Major Interest to Physicians

1:00 P.M. Exhibits Open

3:30 P.M. Reference Committee Meetings

Friday, April 28, 1989

8:00 A.M. Registration Opens

8:00 A.M. Message Center Opens

8:30 A.M. Exhibits Open

9:00 A.M. House of Delegates (Election)

12:00 NOON Golden Merit Award Ceremony and Reception

2:30 P.M. Reference Committee Meetings

5:00 P.M. JEMPAC Political Forum

Friday, April 28, 1989

5:45 P.M. JEMPAC Wine and Cheese Reception

6:30 P.M. Middlesex County Medical Society Reception

Saturday, April 29, 1989

8:00 A.M. Registration Opens

8:00 A.M. Message Center Opens

8:30 A.M. Exhibits Open

9:00 A.M. House of Delegates

1:30 P.M. House of Delegates

2:00 P.M. Exhibits Close

6:00 P.M. Inaugural Reception and Dinner

Sunday, April 30, 1989

8:00 A.M. Registration Opens

8:00 A.M. Message Center Opens

8:30 A.M. General Session—Topic of Major Interest to Physicians

1:00 P.M. Board of Trustees' Meeting

The daily schedule for Thursday, April 27 has been revised. Changes include the scheduling of the House of Delegates opening session at 10:00 A.M. on Thursday, April 27, 1989, and an educational program from 1:00 P.M. to 3:00 P.M., that same day.

The topics for the education programs scheduled for 1:00 P.M., Thursday, April 27, and 8:30 A.M., Sunday, April 30 will be announced at a later date.

The Inaugural Reception and Dinner-Dance honoring President-Elect Paul J. Hirsch, M.D., will be held on Saturday, April 29, 1989.

munization education program. An adult immunization education program will be added to the previously established child immunization education program.

Kimberly Updegove, formerly a research consultant for the Office of Health Policy Analysis at HRET, will be coordinating the program with Rita Clement, program director, Health Promotion. They will be developing educational brochures and posters to distribute to hospital and community health services programs. The goal of these educational tools is to raise the consciousness of both health care providers and the public about the need for adult immunization and to dispel the myth that "childhood" diseases present a danger only to children.

For more information, call the education department at HRET (609/275-4111), Kim Updegove (609/275-4114), or Rita Clement (609/275-4029).

MESSAGE FROM SENATOR BRADLEY Catastrophic Health Care

In June, Congress passed the Medicare Catastrophic Protection Act which makes major improvements in Medicare's coverage of hospital and doctor bills. In 1989, Medicare will pay an entire year's hospital bills

after the patient pays for just the first day of a hospital stay. In 1990, Medicare will pay all covered doctor bills over \$1400 a year. And, by 1992, Medicare will pay for most of the costs of prescription drugs after the patient pays \$600 a year.

This new program will be financed by two premiums—a basic premium of \$60 a year paid by all Medicare beneficiaries (except the poor) and a supplemental premium, ranging from \$23 to \$800 a year, depending on a person's income.

Another part of the legislation will increase home care services to 38 days (or longer if a physician says that additional services are needed).

A second provision will help families who want to care for parents and older relatives in their homes. This respite care program would give family members a short break from the day-to-day tasks of caregiving by allowing up to 80 hours a year of in-home services, including companion services and homemaker/home health aide services.

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LEGISLATIVE UPDATE

Status of Legislation on Which MSNJ Has Taken an Active Position

Bill	Subject	MSNJ Position	Committee	Present Status
S-216 O'Connor	Creates a separate licensing and regulatory board for chiropractic.	Active Opposition	Senate: LIP	Out of committee; 2nd reading
S-219 O'Connor	Provides for the licensing and regulation of nutritionists through a Board of Nutrition within the Department of Law and Public Safety.	Active Opposition	Senate: LIP	In committee
S-263 Dumont	Provides for a three-year statute of limitations, except for fraud, intentional concealment, or nontherapeutic or diagnostic purpose. Minors would have until age 11 on any injury prior to age 8.	Active Support	Senate: JUD	In committee
S-470 Bubba	Requires physicians to personally present and obtain surgical consent forms and signatures. The form shall state the name of any assisting physician that performs surgery under the supervision of the attending.	Active Opposition	Senate: LIP	In committee
S-718 Codey	Amends the certificate of need to include physicians whenever a health service has been regionalized by regulation of the Department of Health. Regulation would terminate within three years, at which time, the commissioner could readopt the regulation.	Active Opposition	Senate: IHW	In committee
S-784 McManimon	Allows psychologists to certify disability.	Active Opposition	Senate: LIP	Passed in Senate; in Assembly committee (Labor)
S-1018 Lipman	Authorizes nurses to practice medicine and to prescribe drugs and devices.	Active Opposition	Senate: LIP	In committee
S-1062 DiFrancesco	Requires every person who has reasonable cause to believe an elderly or disabled person is the victim of abuse or exploitation to report that information to the commissioner of human services or his designee.	Active Support	Senate: IHW	In committee
S-1123 Cardinale	Exempts the private practice of medicine from the certificate of need law.	Active Support	Senate: IHW	In committee
S-1146 Cardinale	Limits noneconomic damage awards to \$100,000.	Active Support	Senate: JUD	In committee
S-1153 Cardinale	Requires that alcoholic beverages be labeled to advise pregnant women of potential harm to fetus when consumed.	Active Support	Senate: IHW	In committee
S-1188 Feldman	Provides that within 60 days of filing an action against a physician, the plaintiff must provide an affidavit from an expert that there has been a negligent deviation from the accepted standards of practice.	Active Support	Senate: JUD	In committee

Bill	Subject	MSNJ Position	Committee	Present Status
S-1205 Feldman	Makes the decision of an administrative law judge final in contested agency actions.	Active Support	Senate: JUD	In committee
S-1208 Feldman	This bill would establish and license two categories of social workers and would create a Board of Social Work Examiners in the Department of Law and Public Safety whose powers and duties, among others, would be to administer the act, examine and license candidates for the various categories of social work, and promulgate rules and regulations necessary for the effective enforcement of the act. The two categories of licensed social work would be (1) social work specialist, who would be required to have a doctorate in social work or a master's degree from an accredited school of social work and (2) social workers who would need a baccalaureate degree from an accredited college or university social work or social welfare program. The bill would "grandfather" in all persons currently in practice, provided they have been in practice in one of the two licensed categories for two of the last five years, and apply to be licensed within 180 days from the effective date of this act.	Active Opposition	Senate: IHW	Passed in Senate; in Assembly committee (HERP)
S-1252 Contillo	Provides for a nonbinding referendum concerning the enactment of a national health plan.	Active Opposition	Senate: IHW	Passed in Senate; in Assembly committee (HHR)
S-1491 Gagliano	Prohibits the licensing and/or practice of physician assistants.	Active Support	Senate: IHW	In committee
S-1541 Pallone	Requires food and hydration to be provided to all patients regardless of consent; does not provide immunity to health professions nor is a penalty for nonobservance provided.	Active Opposition	Senate: IHW	In committee
S-1649 Orechio	Requires health care licensees to accept Medicare determination of their fees.	Active Opposition	Senate: IHW	In committee
S-1705 Bassano	Eliminates joint and several liability.	Active Support	Senate: JUD	In committee
S-1845 Lesniak	Provides for structured payments in civil actions against health care providers when future damages exceed \$250,000. An annuity contract must be offered to guarantee payments.	Active Support	Senate: JUD	Out of committee; 2nd reading
S-2055 VanWagner	Creates a study commission to determine whether the DRG program should be continued.	Active Support	Senate: IHW	In committee
S-2509 Lynch	Provides that physicians, chiropractors, and podiatrists may not use unlicensed aides to provide physical modalities.	Active Opposition	Senate: LIP	In committee

Bill	Subject	MSNJ Position	Committee	Present Status
S-2592 DiFrancesco	Provides for the licensing and regulation of occupational therapy.	Active Opposition	Senate: LIP	In committee
A-88 Villane	This bill would establish and license two categories of social workers and would create a Board of Social Work Examiners in the Department of Law and Public Safety whose powers and duties, among others, would be to administer the act, examine and license candidates for the various categories of social work, and promulgate rules and regulations necessary for the effective enforcement of the act. The two categories of licensed social work would be (1) social work specialists, who would be required to have a doctorate in social work or a master's degree from an accredited school of social work and (2) social workers who would need a baccalaureate degree from an accredited college or university social work or social welfare program. The bill would "grandfather" in all persons currently in practice, provided they have been in practice in one of the two licensed categories for two of the last five years and apply to be licensed within 180 days from the effective date of this act.	Active Opposition	Assembly: HERP	In committee
A-148 Penn	Permits psychologists to certify disability under the temporary disability benefits law.	Active Opposition	Assembly: L	In committee
A-420 Deverin	Creates a new class of licensed practitioners who would function independently and would be permitted to perform such services as the design, fabrication, and application of splints, sensorimotor activities, the use of specifically designed crafts, guidance in the selection and use of adaptive equipment, therapeutic activities to enhance functional performance; prevocational evaluation and training, and consultation concerning the adoption of physical environments for the handicapped. The State Board of Medical Examiners will exercise jurisdiction.	Active Opposition	Assembly: HERP	In committee

Senate Reference Committees

LIP: Labor, Industry, and Professions
SGF&IR&VA: State Government, Federal & Interstate Relations & Veterans Affairs
IHW: Institutions, Health & Welfare
JUD: Judiciary
RFA: Revenue, Finance & Appropriations
CH: Children Services

Assembly Reference Committees

HHR: Health and Human Resources
HERP: Higher Education and Regulated Professions
JUD: Judiciary
SG: State Government
INS: Insurance
SC: Senior Citizens
EDA: Economic Development and Agriculture
L: Labor

Bill	Subject	MSNJ Position	Committee	Present Status
A-470 Colburn	Creates a commission to study the effects of the DRG program and the rate-setting system in New Jersey on services provided in acute care hospitals.	Active Support	Assembly: HHR	Passed in Assembly; in Senate committee (IHW)
A-479 Colburn	Provides that the costs associated with nursing services must be specifically identified in hospital budgets and rating formulas.	Active Support	Assembly: HHR	In committee
A-886 Kern	Increases the penalties for using false credentials to obtain a license or to represent oneself as licensed.	Active Support	Assembly: HERP	In committee
A-1082 Moran	Establishes a public black list to be compiled by the Division of Aging on those physicians whose fees exceed Medicare allowances.	Active Opposition	Assembly: HHR	In committee
A-1532 Doria	Creates a licensing board for chiropractic. Transfers all functions and responsibilities of the State Board of Medical Examiners regarding chiropractic to the new board. Removes the place for a chiropractor from the medical board.	Active Opposition	Assembly: HERP	In committee
A-1538 Doria	Requires that all closed professional liability claims be reported to the Department of Insurance.	Active Opposition	Assembly: INS	In committee
A-1542 Doria	Permits dentists who have had their credentials approved to practice in hospitals.	Active Opposition	Assembly: HERP	Passed in Assembly; in Senate committee (LIP)
A-1544 Doria	Allows HMO beneficiaries free choice of provider. Limits HMO liability to its established fee schedules. In the case of capitation or salaried plans, the Medicaid fee schedule would be used.	Active Support	Assembly: HHR	In committee
A-1591 Bennett	Requires statutory authorization for the licensure or certification of health care practitioners.	Active Support	Assembly: HHR	Passed in Assembly; in Senate committee (IHW)
A-1600 Kelly	Allows nurses who practice in collaboration with physicians to prescribe medications in accordance with protocols submitted to and approved by the State Board of Nursing.	Active Opposition	Assembly: HHR	In committee
A-2305 Karcher	Requires health practitioners to accept Medicare assignments.	Active Opposition	Assembly: HHR	In committee
AR-29 Farragher	Requests Congress to raise fees to doctors participating in Medicare.	Active Support	Assembly: HHR	In committee

THE LOWER RESPIRATORY TRACT— More vulnerable to infection in smokers and older adults



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For respiratory tract infections due to susceptible strains of indicated organisms.

Summary.
Consult the package literature for prescribing information.

Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β -hemolytic streptococci).

Contraindication: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS. Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in

moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.

- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthritis, and frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.

- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.

- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest[®] tablets but not with Tes-Tape[®] (glucose enzymatic test strip, Lilly).

(061088L)

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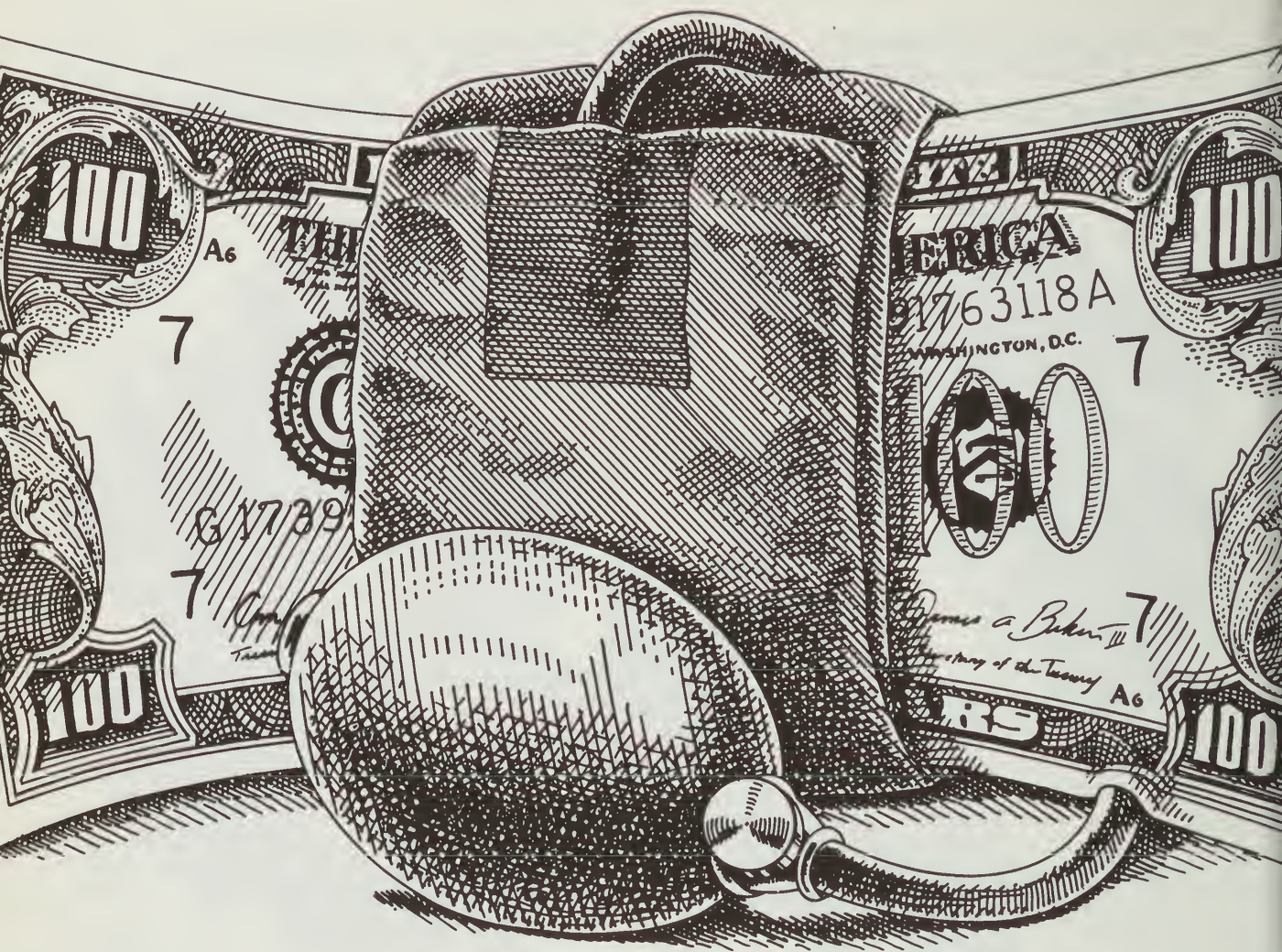
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Mixed Signals from Physical Therapists; AIDS Warning for Funeral Directors; Financial Disclosure Bill; Fight Against Malpractice Surcharge; Involuntary Commitment Law Delayed

MIXED SIGNALS FROM PHYSICAL THERAPISTS

Can somebody please tell us what the Physical Therapy Association really wants? Try this multiple choice:

- a. A law which requires physicians to employ physical therapists in order to provide "physical modalities."
- b. A regulation prohibiting physical therapists from being employed by physicians.
- c. Both of the above.

The correct answer is "c." Never mind that the goals seemingly are mutually exclusive.

Readers of this column may be familiar with answer "a." The physical therapists have had identical bills, S-2509 and A-3166, introduced to prohibit physicians from using any employee, other than a physical therapist, to administer "physical modalities." These include heat, diathermy, cold, ultrasound, ultraviolet rays, cold quartz rays, and electromagnetic rays.

What's new is answer "b." The State Board of Physical Therapy now has proposed a rule which would prohibit PTs from being employed by physicians or physician-owned facilities. The Board's justification for this astonishing proposal is as follows:

"The Board is seeking to address what it perceives as a growing trend in the health care system of having physical therapy services delivered by therapists who are in the employ of, or otherwise indebted to, persons who possess the capacity to authorize the initiation of treatment. Such arrangements, the Board believes, permit the referrers to derive a profit from physical therapy services without allowing consumers to know where their health care dollar is going.

(Note: The foregoing argument will be made invalid by the enactment of the financial disclosure bill described later in this column.)

"In addition, in such situations it is impossible to ascertain the actual cost of the physical therapy services. Employment arrangements wherein the licensee is paid for his or her services by the referring practitioner would be prohibited based upon the Board's belief that such arrangements lead to a compromise of the physical therapist's professional judgment and denial of the patient's freedom of choice. A patient usually is not in a position to shop for physical therapy services, and must rely on both the referrer and the therapist for unbiased recommendations and guidance."

As an aside, the rule also would classify as "professional misconduct" the rendering of treatment by a PT when "the physical therapist may deem such treatment to be unnecessary, even if he or she has received direction from a physician."

The Society is convinced that the PT Board has strayed far beyond its statutory authority in proposing this rule, and we've registered our objections with the attorney general and Division of Consumer Affairs.

It also is interesting to note that the Board is attempting to institute a ban which the legislature already has rejected. A bill which would have prohibited physicians from employing PTs or owning facilities which provide physical therapy services failed in the 1986-1987 legislative session.

Going back to our multiple choice question, the correct answer was "both of the above." The physical therapists apparently want a modalities law and an employment regulation which, when combined, would assure that neither physical therapy nor physical modalities could be obtained in the physician's office or facility.

AIDS WARNING FOR FUNERAL DIRECTORS

Governor Thomas Kean has signed a law requiring funeral directors to be notified in writing if a deceased person they are preparing for burial is infected with AIDS or any other contagious, infectious, or communicable disease.

The law, chapter 125 of the laws of 1988, was signed on September 15 and the AIDS notification took effect immediately. In addition, the State Department of Health has until next March to distribute a comprehensive list of "contagious, infectious, or communicable diseases" about which funeral directors should be warned.

The notification burden is on physicians, registered nurses, and medical examiners who pronounce death and know that the deceased person was infected with a relevant disease. Failure to give notification is punishable by a fine of up to \$1,000.

The law also provides health professionals who give notification immunity from civil or criminal liability, as long as they act in good faith.

FINANCIAL DISCLOSURE BILL

A financial disclosure bill, which acknowledges the physician's right to own or invest in health care services, has cleared the Assembly Health Committee and now is pending final passage in the lower house.

*Mr. Martin is MSNJ's legislative consultant.

The bill, S-734/A-2485, applies to practitioners regulated by the Board of Medical Examiners (physicians, podiatrists, and chiropractors). It recognizes that they can own health care services, and requires them to disclose that relationship whenever they refer a patient to a facility in which they or their immediate family have a financial interest.

The bill was conceived as the Society's alternative to lobbying efforts—primarily by physical therapists—aimed at preventing physicians from owning a variety of health care services. It is sponsored by Senators Richard Codey (D—West Orange) and John Russo (D—Toms River) and Assemblyman Chuck Haytaian (R—Hackettstown).

The bill applies to such services as a bioanalytical laboratory, pharmacy, nursing home, home health care agency, and radiological and ophthalmic facilities.

Disclosure is required if the practitioner owns 5 percent or more of the service, or if the investment exceeds \$5,000. Ownership of a building in which space is leased to a health care service need not be disclosed.

FIGHT AGAINST MALPRACTICE SURCHARGE

Round two of the Society's campaign to defeat the Insurance Department's proposed 5 percent annual surcharge on malpractice premiums has been fought, and we're now preparing for the remainder of the bout.

The second round took place in an October 24 public hearing at the Insurance Department. The Society, its county components, and specialty societies had planned an impressive turnout of physicians to demonstrate medicine's deep-seated opposition to the ill-advised surcharge. Our earlier efforts included corresponding with Governor Kean, Insurance Commissioner Ken Merin, and the entire legislature, as well as distributing press releases to the media explaining our position.

The surcharge was proposed by the Insurance Department as a means to make up some \$60 million in liabilities of the Medical Malpractice Reinsurance As-

sociation, a state-run plan which sold underpriced malpractice insurance for six years beginning in 1976.

Although it was warned several times by legitimate insurance carriers that its premiums were too low, the Medical Malpractice Reinsurance Association insisted on selling cheap insurance throughout its years of operation. As a result, it has accumulated an estimated \$22 million in reserves, but faces at least \$82 million in claims over the next decade.

INVOLUNTARY COMMITMENT LAW DELAYED

Implementation of the state's new involuntary civil commitment law will be delayed for a year under terms of a bill (A-3790) introduced by Assemblyman George J. Otlowksi (D—Perth Amboy). The law, sponsored by Assemblyman Otlowksi, is scheduled to take effect this month.

Absent passage of the bill, the law still cannot become operative; too much work remains to be done. A-3790 simply reflects this reality.

The law expands the criteria under which mentally ill adults can be involuntarily committed to psychiatric hospitals. It will permit patients to be hospitalized prior to their committing an overt act which is dangerous to themselves or others. It also establishes hospital-based screening centers where patients can be evaluated for up to 24 hours, as well as short-term psychiatric units in community hospitals to provide acute care for up to two weeks.

While the concept may sound simple, its implementation has proved to be difficult for the Department of Human Services. The law cannot operate effectively until the network of screening centers and short-term care units is established. Because this work still is in its formative stages, the delay is necessary.

The new law is intended to foster better treatment for the acutely mentally ill by shifting responsibility to community hospitals. State and county psychiatric hospitals would function primarily as facilities for treating chronic mental patients.

ARMY RESERVE OFFERS NEW FINANCIAL INCENTIVES FOR RESIDENTS IN ANESTHESIOLOGY AND SURGICAL SPECIALTIES



If you are a resident in Anesthesiology, Orthopaedic Surgery, or General Surgery including Neurosurgery, Colon/Rectal, Cardiac/Thoracic, Pediatric, Peripheral/Vascular and Plastic Surgery, the Army Reserve has a new and exciting opportunity for you. The New Specialized Training Assistance Program will provide you with financial incentives while you're training in one of these specialties.

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local Army Reserve medical unit with flexible scheduling so it won't interfere with your residency training, and in addition to your regular monthly Reserve pay, you'll receive a stipend of \$678 a month.

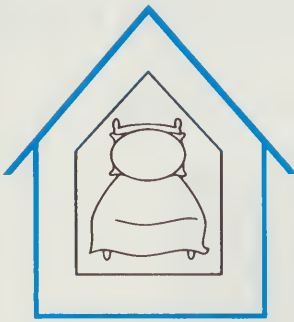
You'll also have the opportunity to practice your specialty for two weeks a year at one of the Army's prestigious Medical Centers.

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Serving All Patients

PALMA E. FORMICA, M.D.

On June 29, 1988, as Dr. James Davis assumed the presidency of the American Medical Association, he challenged physicians to tithe four hours of service a week for the good of the American people. He suggested each of us could contribute to the public good by teaching, becoming involved in community activities, and demonstrating compassion and caring to each individual patient. He urged the leadership of organized medicine to bring this message to all doctors.

Service is a noble part of our vocation as physicians. I am convinced that the members of the Medical Society of New Jersey fulfill this challenge. Thousands of physicians accept both Medicaid and Medicare assignments even when the reimbursement does not cover "turn-key" costs. And we treat patients and the medically indigent with respect and compassion. The state uncompensated care fund reimburses hospitals—not physicians.

Every time we teach students, residents, and patients, we are extending service. Our activities with temples and churches, service organizations, and schools and sports are a means of tithing.

In October, I was invited to a testimonial dinner given by the Cooper Foundation. The award bestowed on Dr. Lindley Reagan of Burlington County honored him for dedicated service to his country, his community, his patients, his family, and his profession. Dr. Reagan epitomizes that covenant of caring which sets physicians apart. It is that other directness which made him become involved in his community for the good of all people. The Cooper award was an example of the other side of the covenant. His peers, his patients, and the community (the Cooper Foundation) recognized his gifts of devotion and service. Each of us can emulate the example of Dr. Lindley Reagan.

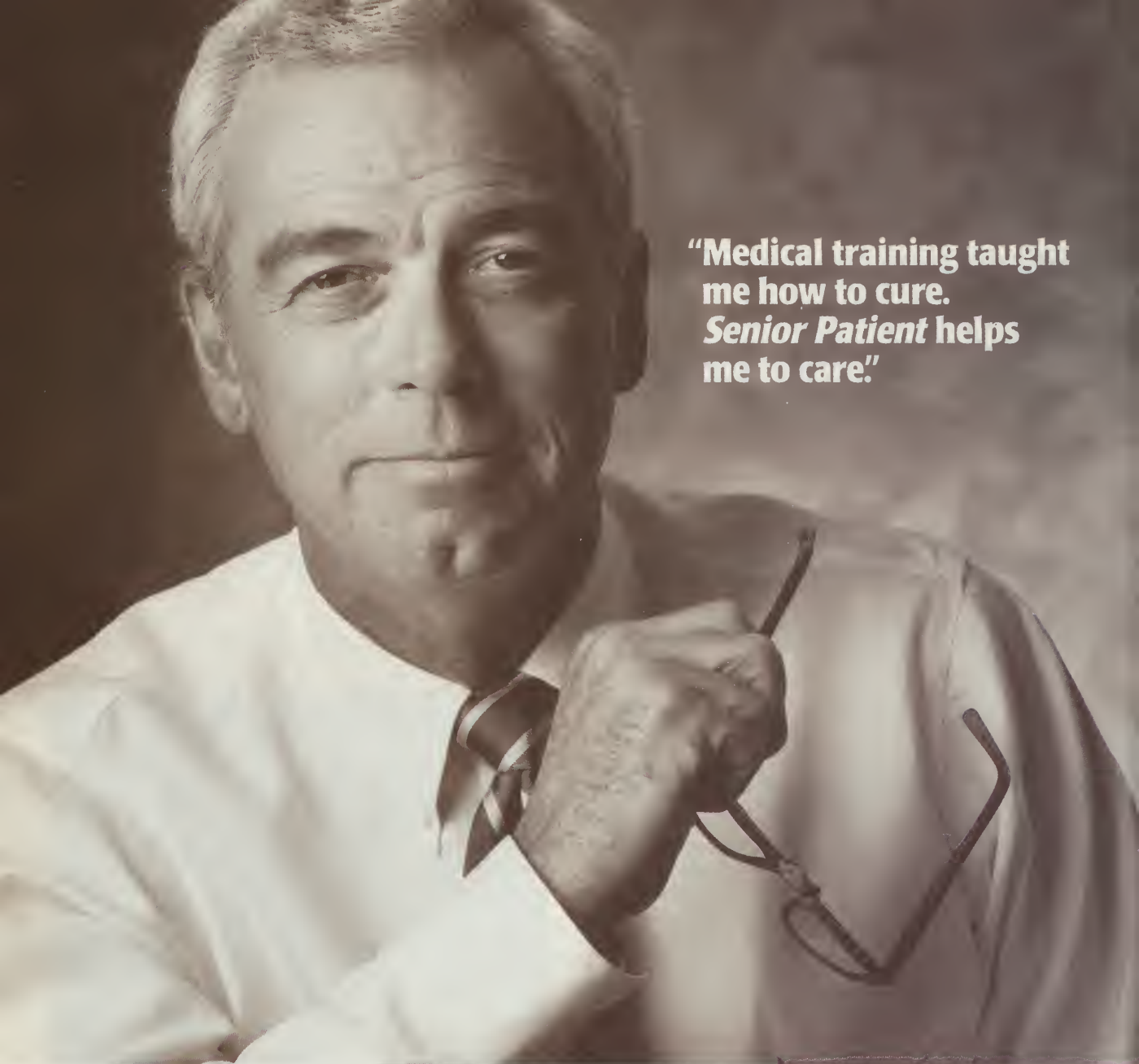


Dr. Formica and Dr. Reagan

I believe our physicians are generous with their gifts of service. Every time I see a doctor's curriculum vitae, I am impressed by the depth and breadth of activities. Many are involved in philanthropic and charitable works in the arts and humanities, with religious organizations, with health planning, with hospital fundraising, and with lectures to special groups such as seniors, AIDS victims, and teenagers.

I urge our younger physicians to be involved. In the thrust of establishing a practice, we should not overlook service to others. Generosity and altruism have their own reward—the impression made by dedication is never lost.

Will we meet the challenge of Dr. Davis?



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The Health of our State

HOWARD D. SLOBODIEN, M.D.*

Most environmental problems are caused by pollution from occupational sources, such as the discharge of industrial wastes, accidentally or otherwise, into potentially hazardous areas.

Radon poses a different problem. It is a naturally occurring "inert" gas, but it presents a serious danger to public and personal health. Radon is the second leading cause of lung cancer, responsible for about 20,000 deaths annually in the United States. Governmental groups are showing increasing concerns. The New Jersey State Department of Environmental Protection warned of the toxic effects of radon more than a year ago. The federal government sounded an alert two months ago. The New Jersey legislature is considering tying real estate transfers to mandatory testing for radon. This draconian proposal should not be necessary; people should be anxious to practice a little preventive medicine that does not require the extreme sacrifice of changing one's lifestyle. Although there are radon belts, the gas can be present outside these regions; radon has many skip areas. New Jersey citizens should give priority to testing their homes for radon.

This issue is devoted to the occupational and environmental health of New Jersey, including the problems posed by radon. The October 1988 issue of *NEW JERSEY MEDICINE* (page 783) highlights the state Radon Outreach Program. The life you save may very well be your own, or that of your child.

Occupational health, which deals with the reciprocal influences of the workforce and of health and which forms part of the broad subject of "environmental health," has a history that can be traced back to prehistoric times, e.g. the "cave-gout" of the neolithic man.

Hippocrates wrote of environment and health and described lead colic in a metal extractor. Pliny told of poisoning by lead and mercury.

Further contributions were made to the understanding of mining risks by Agricola and by Paracelsus, both in the 16th century. Many others added their observations.

But Bernardino Ramazzini (1633-1714) generally is acknowledged to be the father of occupational medicine. In *De morbis artificum deatriba* he documented illnesses related to dozens of trades, including those of stone masons, potters, printers, and miners. In addition, he was an excellent epidemiologist, describing such plagues as the malarial epidemics in the area. He has been honored in Europe, America, and, interestingly, in Keio, Japan, where his statue can be seen at the University of Occupational and Environmental Health.

*Correspondence may be addressed to Dr. Slobodien, Editor-in-Chief, *NEW JERSEY MEDICINE*, Two Princess Road, Lawrenceville, NJ 08648.

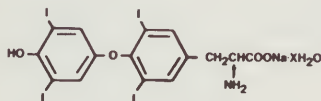
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CLINICAL PHARMACOLOGY:

The principal effect of thyroid hormones is to increase the metabolic rate of body tissues.

The thyroid hormones are also concerned with growth and development of tissues in the young.

The major thyroid hormones are L-thyroxine (T_4) and L-triiodothyronine (T_3). The amounts of T_4 and T_3 released from the normally functioning thyroid gland are regulated by the amount of thyrotropin (TSH) secreted from the anterior pituitary gland. T_4 is the major component of normal thyroid gland excretions and is therefore the primary determinant of normal thyroid functions. T_4 acts as a substrate for physiologic deiodination to T_3 in the peripheral tissues. The physiologic effects of thyroid hormones are mediated at the cellular level primarily by T_3 .

LEVOXINE (L-thyroxine) tablets taken orally provide T_4 which upon absorption can not be distinguished from T_4 that is secreted endogenously.

INDICATIONS AND USAGE:

LEVOXINE (L-thyroxine) tablets are indicated as replacement or supplemental therapy for diminished or absent thyroid function (e.g., cretinism, myxedema, nontoxic goiter or hypothyroidism generally, including the hypothyroid state in children, in pregnancy and in the elderly) resulting from functional deficiency, primary atrophy, from partial or complete absence of the gland or from the effects of surgery, radiation or antithyroid agents. Therapy must be maintained continuously to control the symptoms of hypothyroidism.

CONTRAINDICATIONS:

L-thyroxine therapy is contraindicated in thyrotoxicosis, acute myocardial infarction and uncorrected adrenal insufficiency.

WARNINGS:

Drugs with thyroid hormone activity, alone or together with other therapeutic agents, have been used for the treatment of obesity. In euthyroid patients, doses within the range of daily hormonal requirements are ineffective for weight reduction. Larger doses may produce serious or even life-threatening manifestations of toxicity, particularly when given in association with sympathomimetic amines such as those used for their anorectic effects.

PRECAUTIONS:

General — Caution must be exercised in the administration of this drug to patients with cardiovascular disease. Development of chest pains or other aggravation of the cardiovascular disease requires a reduction of dosage.

Information For The Patient — Patients on thyroid preparations and parents of children on thyroid therapy should be informed that:

1. Replacement therapy is to be taken essentially for life, with the exception of cases of transient hypothyroidism, usually associated with thyroiditis, and in those patients receiving a therapeutic trial of the drug.
2. They should immediately report during the course of therapy any signs or symptoms of thyroid hormone toxicity, e.g., chest pain, increased pulse rate, palpitations, excessive sweating, heat intolerance, nervousness, or any other unusual event.
3. In case of concomitant diabetes mellitus, the daily dosage of antidiabetic medication may need readjustment as thyroid hormone replacement is achieved. If thyroid medication is stopped, a downward readjustment of the dosage of insulin or oral hypoglycemic agent may be necessary to avoid hypoglycemia. At all times, close monitoring of urinary glucose levels is mandatory in such patients.
4. In case of concomitant oral anticoagulant therapy, the prothrombin time should be measured frequently to determine if the dosage of oral anticoagulants is to be readjusted.
5. Partial loss of hair may be experienced by children in the first few months of thyroid therapy, but this is usually a transient phenomenon and later recovery is usually the rule.

Laboratory Tests — The patient's response to thyroid replacement may be followed by laboratory tests such as serum thyroxine (T_4), serum triiodothyronine (T_3), free thyroxine index and thyroid stimulating hormone (TSH) blood levels.

Drug Interactions — In patients with diabetes mellitus, addition of thyroid hormone therapy may cause an increase in the required dosage of insulin or oral hypoglycemic agents. Therefore, patients with diabetes mellitus should be observed closely for possible changes in antidiabetic drug dosage requirements.

Patients stabilized on oral anticoagulants who are found to require thyroid replacement therapy should be watched very closely when therapy is started. If a patient is truly hypothyroid, it is likely that a reduction in anticoagulant dosage will be required. No special precautions appear to be necessary when oral anticoagulant therapy is begun in a patient already stabilized on maintenance thyroid replacement therapy.

Cholestyramine binds both T_4 and T_3 in the intestine, thus impairing absorption of these thyroid hormones. In vitro studies indicate that the binding is not easily removed. Therefore, four to five hours should elapse between administration of cholestyramine and thyroid hormones.

Estrogens tend to increase serum thyroxine-binding globulin (TBG). In a patient with a non-functioning thyroid gland who is receiving thyroid replacement therapy, free thyroxine may be decreased when estrogens are started thus increasing thyroid requirements. However, if the patient's thyroid gland has sufficient function the decreased free thyroxine will result in a compensatory increase in thyroxine output by the thyroid. Therefore, patients without a functioning thyroid gland who are on thyroid replacement therapy may need to increase their thyroid dose if estrogens or estrogen containing oral contraceptives are given.

Drug/Laboratory Test Interactions — The following drugs or moieties are known to interfere with laboratory tests performed on patients taking thyroid hormone: androgens, corticosteroids, estrogens, oral contraceptives containing estrogens, iodine-containing preparations, and the numerous preparations containing salicylates.

1. Changes in TBG concentration should be taken into consideration in the interpretation of T_4 and T_3 values. In such cases, the unbound (free) hormone should be measured. Pregnancy, estrogens, and estrogen-containing oral contraceptives increase TBG concentrations. TBG may also be increased during infectious hepatitis. Decreases in TBG concentrations are observed in nephrosis, acromegaly, and after androgen or corticosteroid therapy. Familial hyper- or hypo-thyroxine-binding-globulinemias have been described. The incidence of TBG deficiency approximates 1 in 9000. The binding of thyroxine by thyroid-binding prealbumin (TBPA) is inhibited by salicylates.

2. Medical or dietary iodine interferes with all in vivo tests of radio-iodine uptake, producing low uptakes which may not be reflective of a true decrease in hormone synthesis.

3. The persistence of clinical and laboratory evidence of hypothyroidism in spite of adequate dosage replacement indicates either poor patient compliance, poor absorption, excessive fecal loss, or inactivity of the preparation. Intracellular resistance to thyroid hormone is quite rare.

Carcinogenesis, Mutagenesis, And Impairment

Of Fertility — A reportedly apparent association between prolonged thyroid therapy and breast cancer has not been confirmed and patients on thyroid for established indications should not discontinue therapy. No confirmatory long-term studies in animals have been performed to evaluate carcinogenic potential, mutagenicity, or impairment of fertility in either males or females.

Pregnancy — Category A — Thyroid hormones do not readily cross the placental barrier. The clinical experience to date does not indicate any adverse effect on fetuses when thyroid hormones are administered to pregnant women. On the basis of current knowledge, thyroid replacement therapy to hypothyroid women should not be discontinued during pregnancy.

Nursing Mothers — Minimal amounts of thyroid hormones are excreted in human milk. Thyroid is not associated with serious adverse reactions and does not have a known tumorigenic potential. However, caution should be exercised when thyroid is administered to a nursing woman.

Pediatric Use — Pregnant mothers provide little or no thyroid hormone to the fetus. The incidence of congenital hypothyroidism is relatively high (1:4,000) and the hypothyroid fetus would not derive any benefit from the small amounts of hormone crossing the placental barrier. Routine determinations of serum (T_4) and/or TSH is strongly advised in neonates in view of the deleterious effects of thyroid deficiency on growth and development.

Treatment should be initiated immediately upon diagnosis, and maintained for life, unless transient hypothyroidism is suspected; in which case, therapy may be interrupted for 2 to 8 weeks after the age of 3 years to reassess the condition. Cessation of therapy is justified in patients who have maintained a normal TSH during those 2 to 8 weeks.

ADVERSE REACTIONS:

Adverse reactions are due to overdosage and are those of induced hyperthyroidism.

OVERDOSAGE — Excessive dosage of thyroid medication may result in symptoms of hyperthyroidism. Since, however, the effects do not appear at once, the symptoms may not appear for one to three weeks after the dosage regimen is begun. The most common signs and symptoms of overdosage are weight loss, palpitation, nervousness, diarrhea or abdominal cramps, sweating, tachycardia, cardiac arrhythmias, angina pectoris, tremor, headache, insomnia, intolerance to heat and fever. If symptoms of overdosage appear, discontinue medication for several days and reinstitute treatment at a lower dosage level.

Laboratory tests such as serum T_4 , serum T_3 and the free thyroxine index will be elevated during the period of overdosage.

Complications as a result of the induced hypermetabolic state may include cardiac failure and death due to arrhythmia or failure.

TREATMENT OF OVERDOSAGE — Dosage should be reduced or therapy temporarily discontinued if signs and symptoms of overdosage appear. Treatment may be reinstituted at a lower dosage. In normal individuals, normal hypothalamic-pituitary-thyroid axis function is restored in 6 to 8 weeks after thyroid suppression.

Treatment of acute massive thyroid hormone overdosage is aimed at reducing gastrointestinal absorption of the drugs and counteracting central and peripheral effects, mainly those of increased sympathetic activity. Vomiting may be induced initially if further gastrointestinal absorption can reasonably be prevented and barring contraindications such as coma, convulsions, or loss of the gagging reflex. Treatment is symptomatic and supportive. Oxygen may be administered and ventilation maintained. Cardiac glycosides may be indicated if congestive heart failure develops. Measures to control fever, hypoglycemia, or fluid loss should be instituted if needed. Antiadrenergic agents, particularly propranolol, have been used advantageously in the treatment of increased sympathetic activity. Propranolol may be administered intravenously at a dosage of 1 to 3 mg over a 10 minute period orally, 80 to 160 mg/day, especially when no contraindications exist for its use.

DOSAGE AND ADMINISTRATION:

The goal of therapy should be the restoration of euthyroidism judged by clinical response and confirmed by appropriate laboratory tests such as serum thyroxine (T_4), serum triiodothyronine (T_3), free thyroxine index and thyroid stimulating hormone (TSH) blood levels. The age and general condition of the patient and the severity and duration of hypothyroid symptoms determine the starting dosage and the rate of incremental dosage increase leading to a final maintenance dosage.

In otherwise healthy adults, the recommended initial dosage is 25 to 100 mcg (0.025 to 0.1 mg) daily, while the predicted maintenance dose of 100 to 200 mcg (0.1 to 0.2 mg) daily may be achieved in two to three weeks.

In the elderly patient with long standing disease, evidence of myxedema, or evidence of cardiovascular dysfunction, the initial dose may be as little as 12½ mcg (0.0125 mg) per day. Incremental increases of 25 mcg (0.025 mg) per day at 3 to 4 week intervals may be instituted depending on patient response. It is the physician's judgement of the severity of the disease and close observation of patient response which determine the rate and extent of dosage increase.

In infants and children there is a great urgency to achieve thyroid replacement because of the critical importance of thyroid hormone in sustaining growth and maturation. Despite the smaller body size, the dosage needed to sustain a full rate of growth, development and general thriving is higher in the child than in the adult. The recommended daily replacement dosage of L-thyroxine in childhood is: 0-1 years: 5-6 mcg; 1-5 years: 3-5 mcg/kg; 6-12 years: 4-5 mcg/kg of body weight daily.

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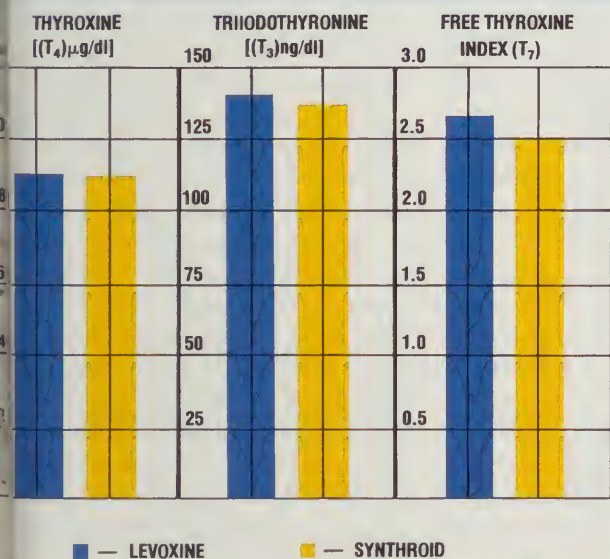
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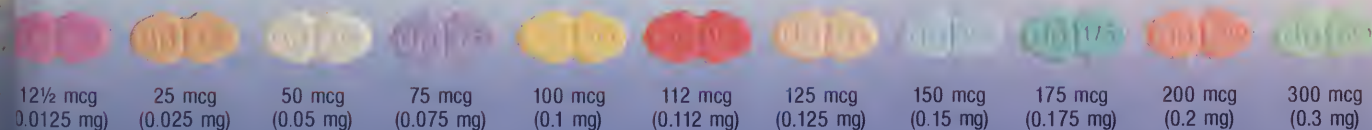
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Environmental and Occupational Health

BERNARD D. GOLDSTEIN, MD

American society is characterized by a growing insistence on the citizen's right to understand and to participate in all areas of individual concern. As physicians, we have observed how this phenomenon has changed the practice of medicine. This insistence on being an informed decision maker has occurred at a time when improved overall health status, associated with advances in understanding the causes of illness, have led the public to expect the right to good health and an explanation for illness. Furthermore, public concern often is focused on an external factor causing a disease.

Among the external factors receiving particular attention in recent years has been the role of chemical and physical agents in the workplace and general environment. Injury and illness no longer are accepted as an inevitable consequence of occupations. Current public concern with chemical contamination of the general environment parallels the Sanitary Revolution of the mid-19th century. New laws, new regulatory agencies, and literally billions of dollars have been directed towards this problem. Of particular concern to the public has been the understanding that there not only is a potential threat of chemical and physical agents in the general environment or workplace, but that the effects of these agents can be insidious, developing after decades of exposure. The nature of such effects, particularly cancer and reproductive hazards, further has concerned the public.

In New Jersey, the public's discontent with chemical exposures has been particularly evident. In a poll taken before the last gubernatorial election, over 40 percent of the electorate listed the environment as the state's number one issue; the second choice, the economy, was chosen by only 12 percent of the voters.

Dr. Goldstein is the Director of the Environmental and Occupational Health Sciences Institute, and guest editor of this special issue.

The extent to which occupational and environmental factors impact on medical practice is difficult to determine. Whatever the actual impact, there is no question that diagnosis, treatment, and the prevention of the resultant diseases are to a greater or lesser degree part of the practice of every primary care practitioner and most specialists.

It is likely that occupational and environmental medicine problems more frequently will be brought to the attention of physicians. Community right-to-know provisions of the new Superfund Act and new worker right-to-know laws, guarantee that the public will be better informed about their exposure to chemicals at work and in their communities. This knowledge will lead to expressions of concern or questions to physicians. In addition, the controversial aspects of environmental problems increasingly are being dealt with locally. The public will be turning to their physicians for informed judgments.

It is impossible to cover every relevant topic in this issue of *NEW JERSEY MEDICINE*. The selection and depth of each presentation was based on patient experience at the UMDNJ-Robert Wood Johnson Medical School Environmental and Occupational Health Clinic, and communications with physicians.

The Environmental and Occupational Health Clinic (201/247-2511) is part of the Environmental and Occupational Health Sciences Institute (EOHSI), a joint program of Rutgers University and UMDNJ-Robert Wood Johnson Medical School. It is a unique, widely diversified academic program with a range of expertise that includes medicine, basic toxicology, and public education. The New Jersey State Departments of Health and of Environmental Protection have been very active in developing programs aimed at providing pertinent information to physicians and the public.

We hope this special issue will be of value to all readers; and we welcome the opportunity to provide support to physicians regarding environmental and occupational health problems. ■

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Environmental Health in New Jersey

BERNARD D. GOLDSTEIN, MD
AUDREY R. GOTSCH, DPH
PAUL J. LIOY, PhD

New Jersey is in the unenviable position of leading the nation in almost all measures of environmental risk. By a large margin, we have the most Superfund hazardous waste sites, close to one out of six sites in the entire country exist in our state. Our drinking water supplies are under siege due to a combination of multiple chemical sources on or under the ground, a relatively heavy reliance on well water and, for much of the state, an underlying soil structure that acts like blotting paper in spreading unwanted chemicals. Air pollution, while arguably worse in other states, still is a major concern, with summer ozone episodes, carbon monoxide, and volatile toxic organic chemicals as our biggest problems. The perceived health effect of pollution at the Jersey shore has had an impact on our way of life this summer. Dealing with hazardous waste from industry in New Jersey has been a topic of major attention for many years. Now, we are beginning to realize that our household garbage is a potential source of significant pollution, particularly as our landfills are at capacity, and we need to consider incineration or other means of dealing with trash. With all of our manmade problems, it seems unfair that we also have one of the highest cancer risks from natural radon in the nation.

There are two major causes for New Jersey's preeminence in environmental problems. The most apparent one is the historic and present size of our chemical, petrochemical, and pharmaceutical industries. We have the largest chemical industry in America. While the modern chemical industry runs under self-imposed or external restraints which are highly effective compared to past activities, risks still remain, particularly those associated with the

transport of chemicals and accidental occurrences. Use of chemicals by smaller industries not readily regulated by authorities remains problematic.

The second major cause for New Jersey's environmental health concerns is not directly due to industry, but reflects demographics. New Jersey, by far, is the most densely populated state in America. Our chemical industry and its detritus are thus cheek-by-jowl with all of us—not off in some distant and sparsely populated corner of the state. Many of our leading environmental problems reflect the actions of our dense population. Suburban sprawl increases reliance on cars and creates traffic problems and air pollution; gasoline stations with leaking underground storage tanks contribute to water pollution; and necessary waste disposal facilities are difficult to locate away from populated areas.

As described by Michael Greenberg in this issue, our high population density also has very important implications as we try to unravel the extent to which environmental pollutants are responsible for adverse health consequences in New Jersey. In particular, does the higher cancer rate in New Jersey reflect our exposure to environmental chemicals, or does it best correlate with factors associated with the suburban lifestyle?

ROLE OF THE PHYSICIAN

Realizing the public has an increased awareness and concern regarding environmental and occupational health issues, a statewide survey of New Jersey residents was conducted in 1985 by the Department of Environmental and Community Medicine, UMDNJ-Robert Wood Johnson Medical School. One of the purposes of the survey was to determine the public's use and perceived reliability of information sources. As noted in the Table, physicians were ranked lower than the media for use as an information source, but much higher for information

Requests for reprints may be addressed to Dr. Goldstein, Department of Environmental and Community Medicine, UMDNJ-Robert Wood Johnson Medical School, Piscataway, NJ 08854-5635.

reliability. Mass media sources, on the other hand, were ranked highest for use, though comparatively low for reliability.

As practitioners in New Jersey communities, physicians have assumed leadership roles in a variety of environmental health issues. For example, concern regarding the potential for increased risk of infectious diseases when swimming in ocean waters along the New Jersey shore led a number of New Jersey physicians to organize a group known as S.O.S. (Save Our Shores). Due in part to the efforts of this group, funds were secured to conduct an epidemiological study during summer 1988 to determine if there is an increased risk of contracting infectious diseases when swimming in New Jersey ocean waters.

This special issue of *NEW JERSEY MEDICINE* has been designed to provide the busy practitioner with highlights from a wide range of information about environmental and occupational pollutants that may be of concern to patients; the exposure to pollutants also may be the etiology for presenting symptoms. In order to function effectively as a physician dealing with potential environmental health problems, the basic concepts of exposure must be understood. In fact, it is this focus on exposure which distinguishes environmental medicine from other areas of medicine. Through understanding human exposure pathways, the physician not only will readily be able to diagnose chemically caused illness, but will be readily able to act preventively to protect family members, workers, and communities from potential illness.

POLLUTANTS

Pollutants that can cause human health effects are contained in a variety of media: air, water, soil, and food. Exposure results from contaminants in one of these media, such as asbestos in the air, or from multimedia pollution problems.

When analyzing a problem due to an environmental pollutant, the following factors have to be considered: identification of the source and the magnitude of the emission; the transport of the compound—how it moves from the source to the human body; transformation of the different pollutants when they react and form secondary products which can be less toxic or more hazardous than the initial compounds; and deposition within the human body—determined by the entering pathways into the body, as well as how the pollutant is metabolized and retained by specific organs.

Air Pollutants. Exposure to air pollutants by both direct or indirect exposure, can occur indoors as well as outdoors. Indoor air pollution has been recognized as a significant problem in the United States.

With the exception of ozone, outdoor air pollutants in the United States have decreased, particularly in New Jersey. However, ozone, which is formed through photochemical reactions with sunlight and other pollutants usually derived from automobile exhaust, remains a significant summertime dilemma. The importance of understanding the conjunction of human activities with air pollution peaks is exemplified by symptomatology and pulmonary function deficits observed in exercising children who

Table. Rankings of information sources accessed by New Jersey residents by level of use and perceived reliability.

Source	Use*	Reliability**
Newspaper articles	1	12
Television	2	9
Magazines	3	8
Medical columns in newspapers	4	6
Public service advertisements	5	7
Public interest groups	6	2
Radio	7	13
Physician	8	4
Friends	9	17
Cable television	10	11
Employer	11	14
Government publication	12	5
Medical schools	13	1
Company newspaper	14	15
Continuing education course	15	3
Employee health facility	16	10
Union	17	16

*The means from which this rank list was derived ranged from 1.5-3.27, where 1= "I receive a great deal of information from this source" and 4= "I receive no information from this source."

**The means from which this rank list was derived ranged from 2.4-3.5.

Rs= .117; $P>.10$

will be expected to be out-of-doors on those sunny days when the meteorology favors ozone formation. As ozone develops in the lower atmosphere only after a few hours of sunlight on smoggy days, exercising early in the morning is preferred to late afternoon or early evening.

Water Pollutants. The water pathway deals with sources that range from a major factory effluent to the local plating shop dumping waste into a creek. Although there are state and federal regulations to prevent this from occurring, on occasion, surface waters become contaminated and must be treated at sewage and water treatment plants before they can be used by humans.

Ground water sources for municipal water supplies or private wells also may become polluted. Private well contamination is a significant concern in New Jersey and must be evaluated on a case by case basis. A common source is leaking underground storage tanks, such as tanks used to store petroleum products at gasoline stations. Relatively cheap carbon filters can be easily installed on the faucet to remove organic compounds from tap water.

Food pollutants. Exposure from food is very difficult to assess. Except for homegrown fruits and vegetables, food quality usually is associated with a region of the country. Contamination most frequently is due to specific types of pesticides or is due to polluted soil. Other pollutants may increase in concentration during improper food preparation or storage, such as lead from glazed ceramic vessels.

Contaminated Soil. Soil can be contaminated by waste tailings, illegal dumping, or factory wastes that have been deposited in piles and allowed to percolate into the soil. In some cases, contaminants are distributed within abandoned landfills, resulting in pockets of high waste contamination throughout the site. Soil contaminant uptake into the body can be through the skin or, particularly in children, by ingestion. Indirect modes, through uptake into garden vegetables or dust inhalation, are possible.

ASSESSING EXPOSURES

The process of assessing exposures involves the ability to prioritize the level of effort or concern that is attached to the particular pathway. For example, the most important pathway to man for ozone exposure would be outdoor air. Another pollutant, such as trichloroethane, may be emitted through indoor air as a result of outgassing vapors from dry cleaned clothes. Several pathways may be involved in a multimedia problem, such as lead, since it can be emitted into a variety of media along with other toxic elements. The difficulty in dealing with multimedia problems is determining the level of effort necessary to define the concentrations of compounds present and the form presented to the individual

from each pathway. Multimedia analyses have to be directed toward very specific problems; some may be pertinent for individuals while others may deal with problems associated with a much larger population.

In the future, the concentration of compounds, especially in air and water, may well continue to be reduced because of control efforts. However, advances in analytical chemistry inevitably will lead to detection of additional pollutants at levels now below analytical sensitivity. Thus, "vanishing zero" likely will fuel further possible concern. A critical problem will be the small pollutant sources that are not regulated but produce locally high exposure levels that may impact significantly on individuals in specific environments. The symptoms exhibited by patients exposed to these pollutants during a physical examination may be difficult to diagnose because information on the time and duration of exposure frequently is difficult to obtain.

The future also will bring improved techniques to measure exposure. Of particular interest is the potential that the exciting new advances in molecular biology will lead to the ability to detect small amounts of chemicals, or metabolites, attached to DNA or other macromolecules. Such biological markers may provide both an indicator of exposure and a predictor of effect, much like now provided for carbon monoxide exposure and toxicity by measurement of carboxyhemoglobin.

CONCLUSIONS

While it is true that New Jersey residents have had cause to be concerned, findings of a recent study indicate that New Jersey is taking an active role to guide future events. For example, the Conservation Foundation reports that New Jersey ranks third among the 50 states in strength of its environmental programs. The New Jersey Department of Environmental Protection has established the nation's largest state program devoted to hazardous waste management and cleanup. In addition, The Fund for Renewable Energy and the Environment recently chose New Jersey's hazardous waste management program as the best state program in the nation.

With the establishment of an Environmental and Occupational Health Sciences Institute by UMDNJ-Robert Wood Johnson Medical School and Rutgers, The State University of New Jersey, it now will be possible to conduct research in areas that are specific to the needs of our state.

The articles in this issue include examples of current investigations that are taking place in New Jersey regarding reproductive hazards, asbestos, pesticides, risk assessment and communication, indoor air pollution, and dioxin. ■

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Radon in New Jersey

JUDITH B. KLOTZ, DPH
IRIS G. UDASIN, MD

High levels of radon in homes are major public health problems, and represent avoidable causes of lung cancer. The widespread radon problem became known when it was discovered that houses located on specific geological formations had surprisingly high concentrations of this radioactive gas and its decay products. Radon is a radioactive gas in the decay chain of the ubiquitous isotope, uranium-238 (Figure 1). When radon decays, its radioactive decay products, radon progeny or radon daughters, can be inhaled and deposited on the respiratory passage linings.

HEALTH RISKS

Alpha radiation is emitted by short-lived radon decay products. Of all types of radiation, alpha particles are the most damaging to cells. They are highly charged, but are relatively bulky (two protons and two neutrons) and have such a short penetration distance that only a few layers of cells are impacted. They do not pass through skin, nor beyond the respiratory mucosa when in the airway. Physiological and morphometric studies predict a very high radiation dose to the respiratory system from inhalation of radon decay products; both animal studies and epidemiologic investigations corroborate these predictions and show a dose-response relationship of lung cancer with cumulative radon progeny exposure. In fact, there is a remarkable degree of agreement in the carcinogenic dose-response observed in

several species of animals and in the numerous occupational studies of underground miners. As a result, we are quite confident about the type and the approximate degree of cancer induction which result from radon exposure of humans.

Epidemiological correlation studies of lung cancer mortality and typical indoor radon concentrations of geographic areas are not able to discern a correspondence because of population mobility whereby exposures may be accrued in one location and mortality occurs later in another. Further, slight fluctuations of cigarette use have much greater effects on lung cancer rates and statistically obscure any radon effects. However, large individual-based epidemiologic studies may be capable of detecting associations and, for this reason, such investigations are underway in New Jersey and elsewhere.

Occupational evidence consistently suggests that lung cancer risks due to radon are alarmingly high. Perhaps as much as 10 percent of lung cancer in the United States may be related to indoor radon exposure. If extrapolations from the data based on underground miners are correct, the number of lung cancer deaths related to radon might exceed the number of deaths from kidney cancer, and might approximate the mortality from leukemia. It has been estimated that the lung cancer risk resulting from average exposure to 20 pCi/l (or 0.1 WL) is about equivalent to the risk associated with smoking one pack of cigarettes per day. For smokers, the excess risk from radon exposure probably is more than for nonsmokers.

Clinically, the sites of lung cancer induced by radon decay products tend to be tracheal and upper

Requests for reprints may be addressed to Dr. Klotz, Division of Occupational and Environmental Health, New Jersey State Department of Health, CN 360, Trenton, NJ 08625.

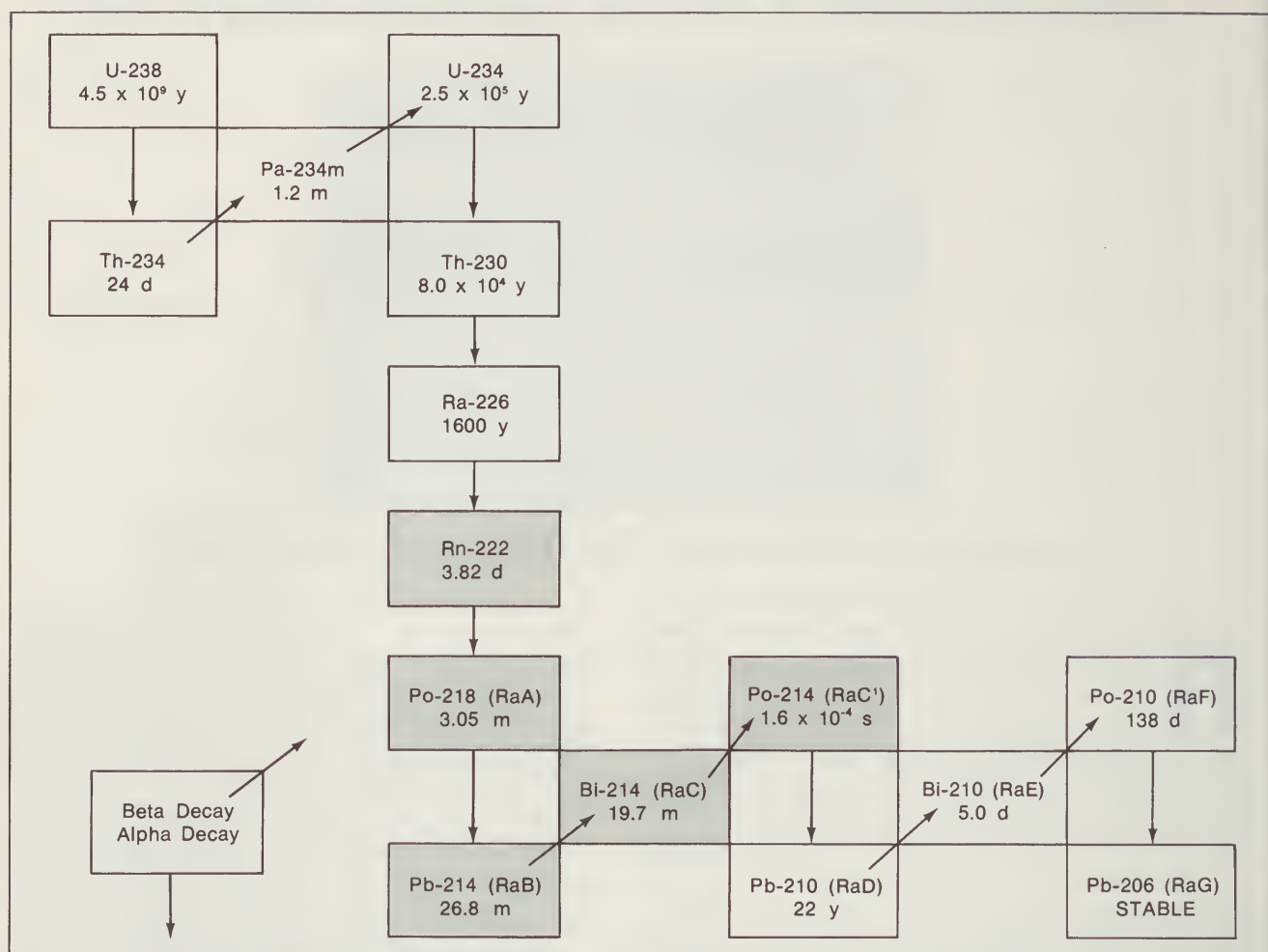


Figure 1. Principal decay scheme of the uranium series, showing radioactive half-lives in years, days, minutes, or seconds (NCRP 1984, Report No. 77). Screened areas show radon and short-lived progeny.

Table. Estimated additional cases of lung cancer in a lifetime if 75 percent of the time is spent at home, for each 1,000 people.

Average Concentration in the Home		Length of Residence		
Radon Gas picocuries per liter (pCi/l)	Radon Progeny working levels (WL)	1 Year	5 Years	20 Years
1 (typical U.S. home)	0.005	less than 1	less than 1	1
4 (guidelines for remediation)	0.02	less than 1	1	6
20	0.1	1	7	28
100	0.5	6	35	140
200	1.0	14	70	less than 250

bronchial, and usually are of squamous or small cell histology.

While radon exposure clearly is less important than smoking as a cause for lung cancer, epidemiologic evidence indicates that the interaction between smoking and radon in lung cancer induction is more than additive, and may even be multiplicative. Recent analyses by the National Research Council also suggest that greater numbers of radon-induced lung cancer occur in men than in women, since excess risk is expressed as a proportion of the underlying risk. They also conclude that the excess exposure causes the greatest increased percentage in risk between 5 and 15 years after the exposure occurs.

Mining studies do not indicate that excesses of other types of cancer or other diseases are caused by radon exposure.

EXPOSURE UNITS

Radon gas is measured in terms of radiation activity; the unit is curies (Ci). Radon progeny, however, traditionally are measured in working levels (WL) referring to former underground mine standards. A typical American house might have 1 picocurie per liter (pCi/l, or 10^{-12} Ci/l) of radon gas. Associated with that radon concentration one would predict about 0.005 WL radon progeny in such a residence. The unit for describing cumulative human exposure is working level month (WLM). People who spend 75 percent of their time in a house with 0.005 WL would accumulate 0.2 WLM in one year or 10 WLM over 50 years. (The traditional WLM is based on only 35 hours per week spent in mines by workers, therefore, in residences about 40 rather than 12 WLM are accrued per year per WL). It has been estimated that about 0.5 rad (500 mrad), or 10 rem (10,000 mrem) of alpha radiation are imparted to the respiratory system for each WLM.

The United States Environmental Protection Agency (EPA) and the Centers for Disease Control recommend remediation of buildings where average radon concentrations are over 4 pCi/l; this level corresponds to 0.8 WLM per year or 40 WLM over 50 years.

There is a significant number of homes in New Jersey which exceed these guidelines, but the guidelines are set as low as currently is practical, and are only about four times the typical levels for the nation.

DISTRIBUTION

Uranium-238 and its products are naturally occurring in soil. Because radon is an inert gas, it may travel easily into the basements of homes as part of soil gas. Construction, heating, and ventilation fac-

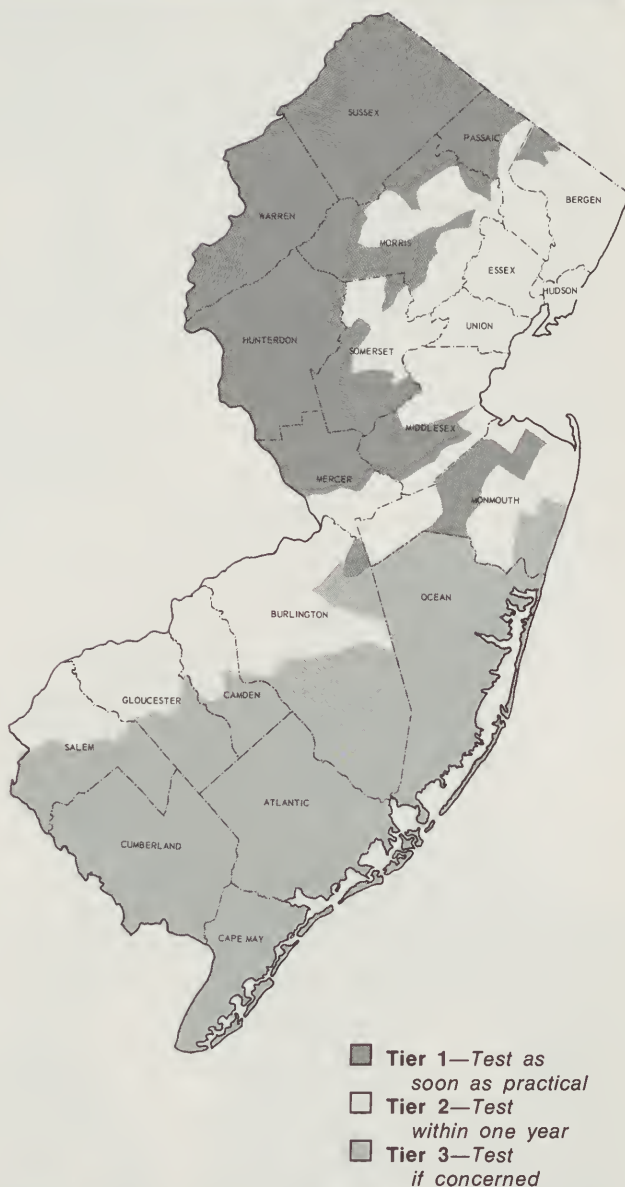


Figure 2. DEP preliminary recommendations for radon testing.

tors greatly influence the degree of accumulation of radon gas inside a house after its entrance from the soil. These factors also influence the relative concentration of radon and its progeny among different floors of the house.

Detectable concentrations of radon and its progeny exist in both outdoor and indoor air. Higher than average concentrations from natural sources have been found throughout the United States. New Jersey has extensive geologic uranium deposits, and consequently there is a widespread potential for high radon levels in indoor air, especially in the northwest section of New Jersey (Figure 2).

In rare instances, many houses with very high radon concentrations from geologic sources are clustered within a small area. Generally, there is

great variation of concentration among neighboring houses. Excess radon derived from industrial radium waste also has affected a few neighborhoods in New Jersey. Although these instances are very troubling, the radon concentrations derived from industrial sources have been lower than those found in some of the clusters due to natural sources.

Radon concentrations also fluctuate greatly over different times of the day and different seasons. As a result, long periods of testing, e.g. three months or one year, are advisable for determining typical radon concentrations of a building, particularly if the concentrations are relatively low. Under those circumstances, long testing periods are required to verify whether further remediation is effective.

In large nonresidential buildings such as schools and offices, radon concentrations tend to be lower than in smaller structures. Furthermore, people tend to spend fewer hours in buildings other than their homes, and thus accumulate less exposure from nonresidential sources. Although nonresidential exposure settings often are important sources of exposures, they generally present a far less serious radon hazard to the public than residences.

PREVENTION

The physician has an important role to play in the prevention of lung cancer due to radon. In areas of New Jersey with high exposure potential, families should be encouraged to obtain the available literature and have their homes tested. State and federal pamphlets may be distributed in the waiting rooms of physicians' offices and distributed to community groups through the auspices of individual physicians and local medical societies. Most importantly, physicians should test their own homes and offices and be sufficiently knowledgeable to discuss radon testing within their own communities.

Prevention of a portion of radon-induced lung cancer can be accomplished through screening of homes in areas with a high potential for exposure, by further testing where screening results are above guidelines, and by remediation of homes which are confirmed to have higher than recommended con-

centrations. The existing body of information on radiation carcinogenesis indicates that there is no threshold dose below which there is no risk. Consequently, since it is impossible to avoid some radon exposure, the emphasis for prevention is on avoidance of unnecessarily high concentrations. It is inappropriate to consider any concentration as safe. State and federal recommendations are based not on acceptability of risk but on feasibility of remediation. Suggested procedures for both testing and mitigation are issued and distributed from governmental agencies.

Federal and state guidance recommend that the urgency for remediation is dependent on radon progeny concentration. For homes with very high levels, temporary short-term exposure reduction can be accomplished while permanent solutions are being considered and implemented. Simple ventilation, e.g. keeping windows open, and adjusting the use of different areas of the home, e.g. limiting time spent in the basement, can reduce immediately the exposure of occupants.

Current research on new building construction is expected to yield methods for constructing radon-resistant houses in the future. Hopefully, building construction code modifications eventually will provide a means for ensuring that new housing stock does not present unnecessary radon exposure.

FURTHER INFORMATION

Additional information on radon is available from the Public Education and Risk Communication Division of the Environmental and Occupational Health Sciences Institute. The New Jersey State Department of Environmental Protection (DEP) offers: "Citizen's Guide to Radon"; "Radon Reduction Methods, A Homeowners' Guide"; and a list of testing and mitigation firms complying with DEP guidelines. The New Jersey State Department of Health publishes: "Facts and Recommendations on Indoor Radon"; "Nonresidential Exposure to Radon: Facts and Recommendations"; and forms for voluntary registration of persons with high accumulations of radon exposure. ■

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Dioxin Exposure and Health

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In terms of the extent of media coverage, dioxin can be viewed as the toxic chemical of the decade. The polarity of views on its toxicity include those who believe it is a clearly identified scourge,¹ and those who believe that no significant human health problems are attributable to it.^{2,3} Federal agencies are in the throes of abandoning research projects on dioxin or reevaluating their risk assessments. Although the potential exposure of humans to dioxins was highlighted and focused by the widespread use of herbicides in Vietnam, the problem of dioxin exposure is by no means unique to veterans of the Vietnam war.

The controversy over dioxin is heightened by the confusion in nomenclature. To a chemist, a dioxin compound is one in which two moieties are linked by two oxygen bridges (Figure 1a). Among the dioxins are those in which the moieties are two benzene rings, hence the term dibenzodioxins (Figure 1b). Almost all attention focuses on polychlorinated dibenzodioxins, particularly those with four or more chlorine atoms (Figure 1c). To the vast majority of people, however, the term dioxin is synonymous with the compound shown in Figure 1d, 2,3,7,8 tetrachloro-para-dibenzodioxin. This compound also is abbreviated as TCDD (although there are two other tetrachloro isomers) or, more correctly, as 2,3,7,8-TCDD. We will use the term 2,3,7,8-TCDD and dioxin synonymously, while "dioxin" will refer to polychlorinated dibenzodioxins. A closely related class of compounds are the polychlorinated dibenzofurans, distinguished from dioxins by the single ox-

ygen bridge (Figure 1e).

In considering the toxicity of dioxin, it is possible to distinguish industrial versus environmental exposure, and acute versus chronic exposure. Acute industrial exposures occurred with accidents in Newark; Nitro, West Virginia; and Seveso, Italy, the latter also caused extensive environmental contamination.⁴ Acute environmental exposures occurred during spraying of 2,3,7,8-TCDD-contaminated defoliants.

Although such exposures are dramatic, the public has been more concerned with long-term low level exposure in the community and in Vietnam.⁵ Although the saga of the Vietnam veteran has been a long time unfolding, community exposure has been emphasized by such well-publicized events as Times Beach, Missouri⁶ and the Iron Bound section of Newark. The most familiar of the dioxin incidents was the contamination of Times Beach, by 2,3,7,8-TCDD which resulted in a federal government decision to buy out all the residents of that town.⁶ The occupational and community contamination of the Iron Bound section of Newark has been extensively studied. A major difference between Times Beach and Newark 2,3,7,8-TCDD episodes is that in the sandy soil of the former, the 2,3,7,8-TCDD was readily bioavailable, while the more complex "organic" soil of Newark held the substance more tenaciously, rendering it mostly biologically unavailable, and therefore reducing its risk.^{7,8}

SOURCES OF DIOXIN EXPOSURE

Chlorinated dibenzodioxins arise in a variety of settings, particularly as a result of combustion under natural as well as artificial conditions⁹ or through

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reactions of chlorinated aromatic compounds. Public attention has focused on garbage incineration as a source of dioxin fallout. More dramatic has been the issue of dioxin exposure of veterans exposed to herbicides. Whereas there are many "dioxins" formed during incineration, the dioxin contaminant of herbicides is almost exclusively 2,3,7,8-TCDD.

Agent Orange was a mixture of two common garden herbicides, 2,4-D and 2,4,5-T (trichlorophenoxyacetic acid). During synthesis of the latter (Figure 2b) from 2,4,5-trichlorophenol (Figure 2a), a certain amount of 2,3,7,8-TCDD was produced (Figure 2c). The configuration of the chlorines on the trichlorophenol assured that it is only the 2,3,7,8 isomer that was accidentally produced. The same dioxin has been found as a contaminant of hexachlorophene, which previously was a commonly used medical antiseptic agent. During the production of pentachlorophenol, the octachloro dibenzodioxin was produced as a byproduct.

HEALTH EFFECTS

The controversy over the magnitude of the 2,3,7,8-TCDD impact on human health focuses on whether human susceptibility is more similar to the guinea pig or to the mouse. The spectrum of health effects attributed to 2,3,7,8-TCDD includes: death, chloracne, cancer, hepatotoxicity, immunosuppression, porphyria, and neurobehavioral and psychological changes.

Chloracne, a potentially severe skin disease is the most characteristic human disorder caused by dioxins. The basic biology of the skin is altered, and the disease may last for decades, even after the cause is removed. Clinically, chloracne is difficult to distinguish from other acneiform lesions; diagnosis is based partly on its distribution, (periorbital, earlobes, neck, abdomen, legs), duration, and history of exposure. It most often results from acute exposures to chlorinated aromatic compounds.¹⁰ Some authorities argue that if chloracne does not occur, one need not worry about dioxin exposure. This view is not widely accepted, for other conditions may rise in animals from chronic low level exposure, even though chloracne does not develop.

2,3,7,8-TCDD is an animal carcinogen.¹¹⁻¹² Several kinds of cancer have been produced, and it appears to have both initiation and promotion effects, i.e. it can itself initiate the development of a new tumor in the absence of any other chemical, and it also can facilitate the development of a tumor initiated by another chemical carcinogen. In humans, however, the evidence for cancer causation is controversial. Cancers of the connective and related tissues, called soft-tissue sarcomas, have been attributed to dioxins,¹³⁻¹⁴ but some studies have questioned this rela-

tionship.¹⁵ More recently, Hodgkin's disease and non-Hodgkin's lymphomas have been attributed to chlorinated phenoxyacetic acids, with the suspicion that dioxins may contribute. An unpublished Veteran's Administration study has shown that marines who served in Vietnam have experienced an excess mortality due to lung cancer and non-Hodgkin's lymphomas.¹⁶ Thus, although the carcinogenic potential of 2,3,7,8-TCDD is recognized, its relation to human cancers is unclear.

There is evidence that dioxin exposure interferes with the body's normal cell-mediated immune mechanisms, and could render it more susceptible to disease. Moreover, the metabolism of porphyrins, chemicals derived from the normal breakdown of heme, is altered, and certain people with dioxin exposure may suffer from the porphyria.¹⁷ In experimental animals, liver disease can be produced by dioxin treatment, and cases of liver damage have been reported in exposed humans as well. 2,3,7,8-TCDD is among the most potent inducers of microsomal enzymes yet identified, and is capable of altering the metabolism of endogenous agents such as hormones and exogenous agents, e.g. foods and environmental chemicals.

Another significant effect in animal experiments is the teratogenic effect, for dioxins can interfere with gestation resulting in miscarriages, stillbirths, or abnormal offspring.¹⁹⁻²⁰ Animal experiments show abnormalities occurring at very low exposure levels. The interpretation of epidemiologic studies of birth defects and adverse reproductive outcomes among Vietnam veterans is controversial,²¹⁻²² and exposure data in such studies were inadequate. Both negative and positive studies are being subjected to very careful epidemiological scrutiny.

The main studies now being conducted on human populations include a National Institute of Occupational Safety and Health study of herbicide manufacturing workers, and studies of Vietnam veterans who are believed to have seen significant exposure to Agent Orange. Studies of the latter are being conducted by the United States Air Force, by the Veterans Administration, and by various states, including the New Jersey Agent Orange Commission.²³ These studies will focus on biochemical, physical, and psychological health effects.

THE POINTMAN PROJECTS

The New Jersey Pointman I study has demonstrated that even 15 to 20 years after presumed exposure, veterans who handled herbicides in Vietnam had significantly higher levels of 2,3,7,8-TCDD in their adipose tissue and blood (averaging greater than 40 parts per trillion and in some cases above 150 parts per trillion), compared with nonexposed

veterans and the general population whose levels average about 5 parts per trillion.³¹ Most importantly, there were no significant differences for other "dioxin" and dibenzofuran compounds,²⁴ supporting the supposition that the source of the elevated TCDD was Agent Orange exposure.

The first Pointman study was predicated on the fact that the gold standard for body burden of 2,3,7,8-TCDD is its concentration in adipose tissue. Lipophilic or hydrophobic compounds naturally concentrate in fatty tissues or cells. The research showed clearly, however, that the concentrations of TCDD in the blood lipids are not appreciably different from the concentration in fat, and the correlation between the two is very high, greater than 0.8 in the Pointman study, and greater than 0.9 in a comparable Centers for Disease Control (CDC) study.²⁵ The Pointman study used a 24-hour fast prior to drawing the blood, but a second study of the same group of men showed no difference in blood levels with and without fasting.²⁶ Accordingly, future studies of dioxin in humans can be based on spot blood samples. However, in order to have adequate sensitivity in the parts per trillion range, the analysis requires over 300 ml of blood.

An important factor in understanding the dynamics and health effects of dioxins is their half-life in the human body. Assuming that an individual had a single exposure, what is the decay curve that characterizes the substance? Recent evidence obtained by the CDC suggests that the half-life may be seven years.²⁵ There are good metabolic reasons for believing that a first order decay curve is not appropriate for the elimination of these compounds from the body, in which case the true half-life may be much longer. Given a seven-year half-life, the observation of a level in excess of 150 parts per trillion in a Vietnam veteran in 1985 can be extrapolated back to a level of 600 parts per trillion in 1971.

Occupationally exposed groups also are being investigated by the National Institute for Occupational Safety and Health. This study is focusing on about 500 workers in the herbicide-manufacturing industry in New Jersey and Missouri.

INCINERATION

About 15 years ago, researchers at Dow Chemical Corporation showed various dioxins are produced by the incineration of natural and synthetic products.⁹ A variety of incinerators has been studied with respect to chemical contaminants in the ash and airborne emissions, and dioxins are among the pollutants found.²⁷ Although present, 2,3,7,8-TCDD is not the major "dioxin" constituent. Risk assessments have been developed for dioxin contamination

from incineration, but the exposure data still are very sparse. Some of the other types of isomers are nearly as toxic and occur in greater quantities. Thus far, in most cases, the amount of total dioxins has been below the parts per billion range.²⁸ Technological developments could be used to reduce the dioxin contamination.

The medical community has not yet been provided with sufficient scientific data to evaluate the safety of garbage incinerators with respect to dioxins

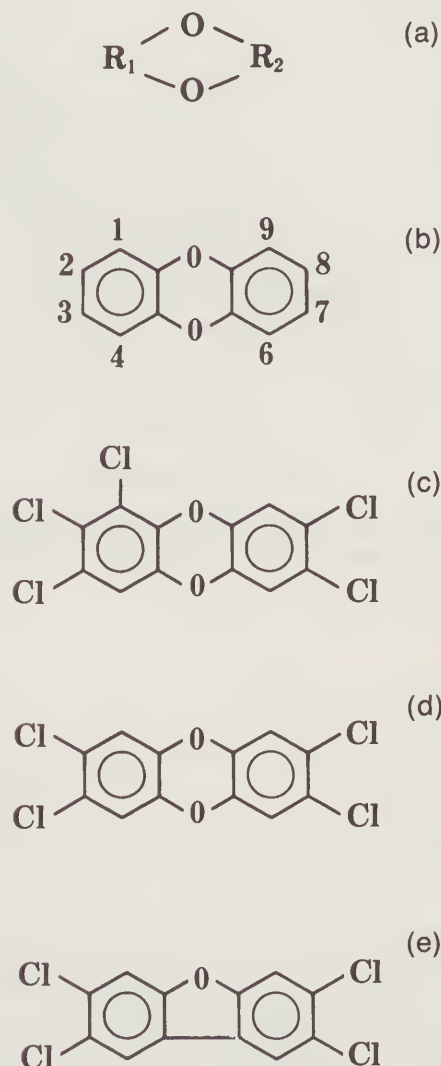


Figure 1. (a) General chemical structure of a dioxin compounds, with two organic moieties bridged by two oxygen atoms; (b) generalized dibenzodioxin with the standardized numbering of the carbon positions; (c) compound 1,2,3,7,8-pentachloro dibenzodioxin; (d) 2,3,7,8-tetrachloro-para-dibenzodioxin, the compound commonly referred to as TCDD or dioxin; (e) 2,3,7,8-tetrachlorodibenzo furan, revealing the single oxygen bridge of the furan compounds.

or other substances. The requisite include extensive environmental monitoring of the air emissions from a variety of facilities over a long period of time. For example, if a measurement is only made once or twice, just after the facility has started up (when it may be at peak efficiency), there is no way to predict what kind of emissions to expect in the weeks just prior to its annual maintenance. Nor is there any indication of the importance of human factors, always a fragile link in a technological system, in maintaining operating conditions at specifications.

It should be possible to construct safe incineration systems, but there is a void between the theory and the realization. A variety of assurances are required before the medical community can rest in comfort that a particular incineration facility poses no health hazard to the surrounding community. New Jersey's Hazardous Substance Management Research Center based at the New Jersey Institute of Technology is in the forefront of research on technology for safely destroying such hazardous chemicals and for assuring that environmental contamination problems do not occur. Moreover, recent research suggests that the concern with dioxin may cause people to overlook other hazards related to incineration emissions such as heavy metals, particularly chromium, which are not destroyed by incineration.³⁸

DIOXIN IN NEWARK

In 1982, studies of TCDD levels in fish and crabs from the Passaic River and Newark Bay led the New

Jersey State Department of Environmental Protection to an unsuspected dioxin-contaminated site.²⁹ The former Diamond Shamrock facility on Lister Avenue in the Ironbound Section of Newark had been a manufacturing site for phenoxyherbicides, and in the wake of industrial accidents and onsite disposal, much of the ground on the property and along access roads was contaminated with 2,3,7,8-TCDD. More than one million dollars was spent on soil analyses and site "mitigation" procedures, and state and academic experts spent much time evaluating the potential for human exposure in terms of available data and risk assessments.

The dioxin in Newark was present in the soil, and human exposure would require either that dioxin-bearing dust became airborne and was inhaled, or that people ingested the soil or were exposed through the skin. Since dioxin is not readily absorbed through intact skin, attention has focused on inhalation and ingestion. Accordingly, a study of the bioavailability of the dioxin in the Newark soil found that the toxicity of the contaminated soil fed to guinea pigs was 50 times lower than would have been expected from the dioxin concentration.⁷ Results showed that the dioxin in this soil had low bioavailability due to its binding to oily material also present in this soil, and then demonstrated that dioxin in soil from Times Beach, Missouri (another dioxin-contamination site), was much more bioavailable.⁸

In view of the uncertainty that human exposure

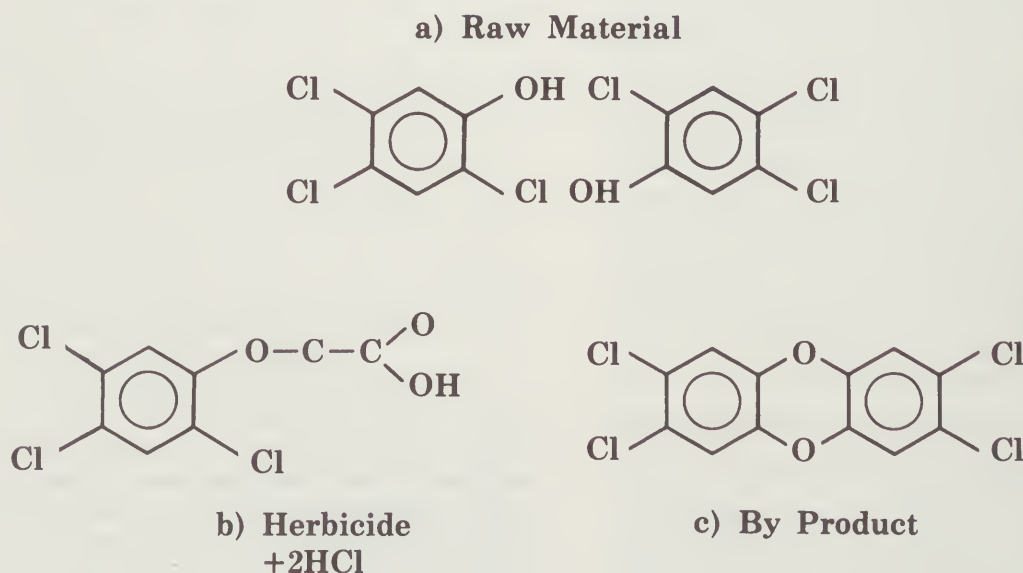


Figure 2. Pathway for the synthesis of the herbicide, 2,4,5-trichlorophenoxyacetic acid (b) from two molecules of the raw material 2,4,5-trichlorophenol [a], resulting also in the formation of the unwanted byproduct, 2,3,7,8-tetrachlorodibenzo dioxin (c).

actually had occurred, a health study of this community has been deferred, and attention has focused instead on the former employees of the company who almost certainly would have had a high level of exposure.

THE PROBLEM: EVALUATING CAUSATION

We identify four problems that have impeded development of a clear statement of human health risks associated with 2,3,7,8-TCDD:

1. The first problem concerns the extreme difficulties involved in adequate laboratory assay of dioxins.³⁰ Few laboratories are equipped to handle the standards necessary. Moreover, the dioxins are present at the parts per trillion level, which would tax the sensitivity and precision of any laboratory, as well as its cost-effectiveness. New Jersey now is making strides to improve the availability of highly sensitive analytical capabilities at reasonable cost.

2. We are confronted by a health effects literature with widely divergent reports. In part, such divergent opinions reflect the fact the authors did not know true exposures, hence in negative studies some of the people with no symptoms or signs may not have been truly exposed, while the same could be said for positive studies.

3. The long latency of some problems attributed to dioxins, particularly cancers, means that adequate time has not yet elapsed to allow a true measure of the ill effect. Hence, scientific reports of certain cancers produced by dioxins in animals and perhaps in Vietnamese people are disquieting.³¹

4. We still do not have a clear picture of how to extrapolate the effects of dioxin on laboratory animals to predict the effects in humans. The EPA recently has revised its estimate of the human risk from dioxin exposure, concluding the TCDD is only about 1/16th as dangerous as previously estimated.

DIOXIN EXPOSURE

There is increasing clamor among veterans and community residents to determine whether they have had significant exposure or adverse health effects due to a host of environmental pollutants, including 2,3,7,8-TCDD.³² Diagnosis of chloracne certainly suggests exposure to chlorinated aromatic compounds, but 2,3,7,8-TCDD is only one of several compounds that could be implicated, and seldom is present in sufficient concentration or quantity to induce chloracne. No other "sentinel" or diagnostic criteria have been established.

One approach would be to focus on evaluating those systems on which chlorinated aromatic compounds have a known impact, namely liver function, uroporphyrin excretion patterns, and cell-mediated immunity. In our experience, however, the main con-

cerns of individuals who have had or suspect chemical exposure of any kind, including TCDD, are cancer and birth defects.

The ability of the clinician to assess such risks and, if appropriate, to reassure an anxious individual, is limited. Introduction of test systems such as DNA-adducts which determine whether an individual's DNA has covalently bound dioxin might reveal individuals with an enhanced risk. Such techniques are on the horizon, but probably will not be practical on a large scale within the next decade.

More realistically, the clinician must make sufficient inquiries to determine the dose or exposure which a patient has encountered. Thus, even being in the presence of a highly toxic material such as 2,3,7,8-TCDD will have little impact if there has been no actual exposure. The recent studies showing low bioavailability of 2,3,7,8-TCDD in certain soils is an important indication that dioxins may be present without posing a significant health hazard.⁵⁸

In the absence of a definitive evidence of exposure, a clinician must explain to a patient the uncertainty regarding risk. One may feel comfortable in reassuring rather than alarming a patient, but ultimately the fact remains that we neither have clear evidence of health effect nor grounds for complacency. Detailed health and exposure studies must be carried out to provide answers. Such studies also may identify for the patient the sources of exposure that are to be avoided, particularly the consumption of contaminated foods or direct contact with contaminated soil.

CONCLUSION

The dioxin issue remains a significant public health problem. While epidemiologists continue to explore the impact of dioxin exposure on human populations, health educators need to be at work putting dioxin contamination into perspective. It appears safe to say that despite its intrinsic toxicity, a major human health impact of dioxin has not yet been demonstrated.

Whether or not a causal link to human disease is shown, dioxin clearly has served to raise the environmental consciousness of a generation, but it should not detract critical attention from other environmental contaminants which pose more significant health hazards.

Whatever the final verdict regarding human disease attributable to 2,3,7,8-TCDD, the situation offers important lessons for environmental and occupational medicine and toxicology. Probably no other single substance, not even lead, asbestos, or benzene, all of which more clearly cause significant disease, has attracted more scientific and nonscientific attention in such a short period of time. ■

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WARNINGS: Status asthmaticus should be considered a medical emergency and is defined as that degree of bronchospasm which is not rapidly responsive to usual doses of conventional bronchodilators. Optimal therapy for such patients frequently requires both *additional medication*, parenterally administered, and *close monitoring*, preferably in an intensive care setting.

Although increasing the dose of theophylline may bring about relief, such treatment may be associated with toxicity. The likelihood of such toxicity developing increases significantly when the serum theophylline concentration exceeds 20 mcg/ml. Therefore, determination of serum theophylline levels is recommended to assure maximal benefit without excessive risk.

Serum levels above 20 mcg/ml are rarely found after appropriate administration of recommended doses. However, in individuals in whom theophylline plasma clearance is reduced for *any reason*, even conventional doses may result in increased serum levels and potential toxicity. Reduced theophylline clearance has been documented in the following readily identifiable groups: 1) patients with impaired renal or liver function; 2) patients over 55 years of age, particularly males and those with chronic lung disease; 3) those with cardiac failure from any cause; 4) neonates; and 5) those patients taking certain drugs (macrolide antibiotics and cimetidine). Decreased clearance of theophylline may be associated with either influenza immunization or active infection with influenza.

Reduction of dosage and laboratory monitoring is especially appropriate in the above individuals. Less serious signs of theophylline toxicity (i.e. nausea and restlessness) may occur frequently when initiating therapy, but are usually transient; when such signs are persistent during maintenance therapy, they are often associated with serum concentrations above 20 mcg/ml. Unfortunately, however, serious side effects such as ventricular arrhythmias, convulsions or even death may appear as the first sign of toxicity without any previous warning. Stated differently: *serious toxicity is not reliably preceded by less severe side effects.*

Many patients who require theophylline may exhibit tachycardia due to their underlying disease process so that the cause/effect relationship to elevated serum theophylline concentrations may not be appreciated.

Theophylline products may cause dysrhythmia and/or worsen pre-existing arrhythmias and any significant change in rate and/or rhythm warrants monitoring and further investigation.

The occurrence of arrhythmias and sudden death (with histological evidence of necrosis of the myocardium) has been recorded in laboratory animals (minipigs, rodents and dogs) when theophylline and beta agonists were administered concomitantly, although not when either was administered alone. The significance of these findings when applied to human usage is currently unknown.

PRECAUTIONS: THEO-DUR TABLETS SHOULD NOT BE CHEWED OR CRUSHED

General: Theophylline half-life is shorter in smokers than in non-smokers. Therefore, smokers may require larger or more frequent doses. Morphine and curare should be used with caution in patients with airway obstruction as they may suppress respiration and stimulate histamine release. Alternative drugs should be used when possible. Theophylline should not be administered concurrently with other xanthine medications. Use with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, in the elderly (especially males) and in neonates. In particular, great caution should be used in giving theophylline to patients with congestive heart failure. Frequently, such patients have markedly prolonged theophylline serum levels with theophylline persisting in serum for long periods following discontinuation of the drug. In individuals who are rapid metabolizers of theophylline, such as the young, smokers, and some non-smoking adults, may not be suitable candidates for once-daily dosing. These individuals will generally need to be dosed at 12 hour or sometimes 8 hour intervals. Such patients may exhibit symptoms of bronchospasm near the end of a dosing interval, or may have wider peak-to-trough differences than desired.

Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to the G.I. tract although gastrointestinal symptoms are more commonly centrally mediated and associated with serum drug concentrations over 20 mcg/ml.

Information for Patients: The physician should reinforce the importance of taking only the prescribed dose and time interval between doses. THEO-DUR tablets should not be chewed or crushed. When dosing THEO-DUR on a once daily (24-hr) basis, tablets should be taken whole and not split. As with any controlled-release theophylline product, the patient should alert the physician if symptoms occur repeatedly, especially near the end of the dosing interval.

DRUG INTERACTIONS: **Drug-Drug:** Toxic synergism with epinephrine has been documented and may occur with some other sympathomimetic bronchodilators. In addition, the following drug interactions have been demonstrated:

Drug	Effect
Theophylline with lithium carbonate	Increased excretion of lithium carbonate
Theophylline with propranolol	Antagonism of propranolol effect
Theophylline with cimetidine	Increased theophylline blood levels
Theophylline with troleandomycin, erythromycin	Increased theophylline blood levels

Drug-Food: THEO-DUR 100 mg Sustained Action Tablets have not been adequately studied to determine whether their bioavailability is altered when given with food. Available data suggest that drug administration at the time of food ingestion may influence the absorption characteristics of theophylline controlled-release products resulting in serum values different from those found after administration in the fasting state.

A drug-food effect, if it is likely to have its greatest clinical significance when high theophylline serum levels are being maintained and/or when large single doses (greater than 13 mg/kg or 900 mg) of a controlled-release theophylline product are given.

THEO-DUR (200, 300, and 450 mg) Sustained Action Tablets: The rate and extent of absorption of theophylline from THEO-DUR 200 mg, 300 mg, and 450 mg tablets when administered fasting or immediately after a moderately high fat content breakfast is similar.

Drug-Laboratory Test Interactions: When plasma levels of theophylline are measured by spectrophotometric methods, coffee, tea, cola beverages, chocolate, and acetaminophen contribute falsely high values.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic potential, mutagenic potential, or the effect on fertility of xanthine compounds.

Pregnancy: Category C—Animal reproduction studies have not been conducted with theophylline. It is not known whether theophylline can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Xanthines should be given to a pregnant woman only if clearly needed.

Nursing Mothers: It has been reported that theophylline distributes readily into breast milk and may cause adverse effects in the infant. Caution must be used if prescribing xanthine to a mother who is nursing, taking into account the risk/benefit of this therapy.

Pediatric Use: Safety and effectiveness of THEO-DUR administered:

- 1 Every 24 hours in children under 12 years of age, have not been established.
- 2 Every 12 hours in children under 6 years of age, have not been established.

ADVERSE REACTIONS: The most consistent adverse reactions are usually due to overdose and are:

- 1 **Gastrointestinal:** nausea, vomiting, epigastric pain, hematemesis, diarrhea.
- 2 **Central nervous system:** headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions.
- 3 **Cardiovascular:** palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias.
- 4 **Respiratory:** tachypnea.
- 5 **Renal:** albuminuria, increased excretion of renal tubular and red blood cells, potentiation of diuresis.
- 6 **Other:** rash, hyperglycemia and inappropriate ADH syndrome.

OVERDOSEAGE; Management: If potential oral overdose is established and seizure has not occurred

- A Induce vomiting.
- B Administer a cathartic (this is particularly important if sustained-release preparations have been taken).
- C Administer activated charcoal.

If patient is having a seizure:

- A Establish an airway.
- B Administer oxygen.
- C Treat the seizure with intravenous diazepam, 0.1 to 0.3 mg/kg up to 10 mg.
- D Monitor vital signs, maintain blood pressure and provide adequate hydration.

Post Seizure Care:

- A Maintain airway and oxygenation.
- B If a result of oral medication, follow above recommendations to prevent absorption of the drug, but intubation and lavage will have to be performed instead of inducing emesis, and the cathartic and charcoal will need to be introduced via a large bore gastric lavage tube.
- C Continue to provide full supportive care and adequate hydration while waiting for drug to be metabolized. In general, the drug is metabolized sufficiently rapid so as not to warrant consideration of dialysis, however, if serum levels exceed 50 mcg/ml charcoal hemoperfusion may be indicated.

CAUTION: Federal law prohibits dispensing without prescription. For full prescribing information, see package insert. Revised 6/87

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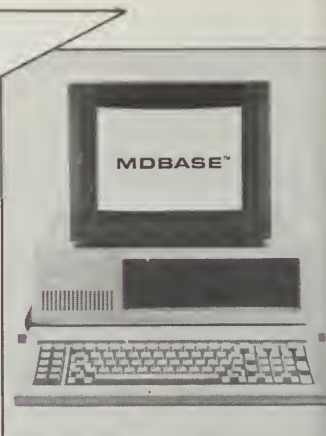
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Asbestos-Related Disease

HOWARD M. KIPEN, MD, MPH

Since 1940, almost 500,000 individuals in New Jersey workplaces have had substantial occupational exposure to asbestos.^{1,2} It is estimated that over 27 million workers in the United States had some occupational asbestos exposure from 1940 to 1979; presently, over 9,000 asbestos-related cancer deaths occur per year as a result of this exposure.³

The ubiquitous presence of asbestos fiber in construction materials and friction products has provided opportunity for exposures that will extend far into the future. Patient awareness of past and potential exposures, as well as actual disease, engender many questions for medical practitioners. Some of these questions will lend themselves to the familiar medical paradigm, and others will call for a public health or preventive medicine approach.

Requests for reprints may be addressed to Dr. Kipen, Department of Environmental and Community Medicine, UMDNJ-Robert Wood Johnson Medical School, Piscataway, NJ 08854.

A primary practitioner may confront one of the following scenarios in relation to asbestos: 1) he may see and counsel an apparently healthy individual who is concerned about past or present exposure to asbestos; 2) he may have need to advise and counsel an individual who has developed pathology likely to be a result of previous asbestos exposure; or 3) he may see an individual with significant pathology, and need to determine whether or not this relates to previous asbestos exposure.

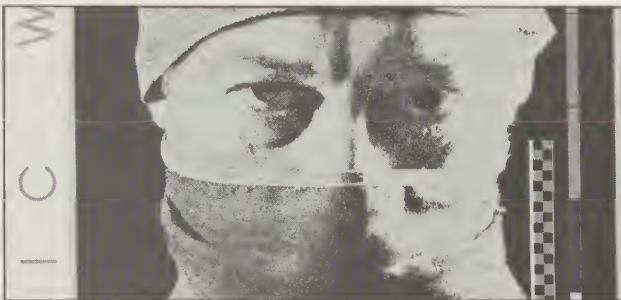
Asbestos is the common name for a group of naturally occurring, fibrous minerals. Because of excellent properties of thermal resistance, strength, and the ability to be woven, these useful fibers were incorporated into a host of different products: textiles, cement and other building products, paper products, friction materials such as brake linings, and insulation products. People were exposed to the highest levels of fibers in factories during manufacture of these products, and, subsequently, to somewhat lower levels during installation and maintenance.

nance of the materials. For New Jersey, important industries using asbestos include shipbuilding in southern and northern New Jersey, insulation and building product manufacture in southern, central, and northern New Jersey, and installation and maintenance of these products in factories, utilities, and offices throughout the state. Brake repair workers also may be exposed, as well as workers in the newest job category, asbestos removal.

TOXICOLOGY AND EPIDEMIOLOGY

The toxic properties of asbestos, and the human response to it, have made asbestos easier to study than other workplace toxins because of its distinctive "signature" on chest x-ray. Thus, far more is known about the clinical effects of asbestos than most other toxic workplace agents, especially about its potential to cause disease in nonoccupational settings. Asbestos exposure occurs through inhalation and ingestion, but toxicity has only been documented from the former. However, many inhaled asbestos fibers are ingested following clearance from the lungs and upper airways. Asbestos fibers do not produce symptomatic irritation of the upper or lower airways at the time of inhalation. In fact, even for occupationally exposed individuals, it is not common to see clinically apparent disease manifestations in the first 10 to 20 years of exposure, even when exposure was continuous.

The earliest clinical response to asbestos exposure may be a benign pleural effusion. This occurs in approximately 20 percent of industrially exposed workers within 10 to 20 years of onset of exposure, some as early as only a few years from onset. Fre-



quently, the effusion may be subclinical, and the only residual is a blunted costophrenic angle on chest x-ray.⁴

The pathologic response best associated with asbestos exposure is fibrosis, both of the lung interstitium and of the pleura. Although pulmonary fibrosis may be present histopathologically at earlier times, it is not radiographically apparent before 10 years from onset of exposure, and relatively uncommon at 10 to 20 years. Radiographic evidence of fibrosis then becomes more and more common in the third and later decades from onset of exposure, such

that more than half of the individuals in many moderately to heavily exposed groups have developed radiographic abnormalities. This is well documented for a group of New York and New Jersey insulation workers.⁵

Carcinogenesis is the other major toxic response to asbestos exposure with usual latencies from first exposure of 20 to 40 years. One-pack-a-day smokers develop lung cancer about 10 times more often than do nonsmokers. Lung cancer (all cell types) occurs approximately 5 times more frequently in asbestos-exposed insulation workers, when compared with a smoking-matched control group, but over 50 times more frequently when compared to nonsmoking, nonasbestos exposed controls. It is the multiplication of these two risks that results in the astronomical rate of lung cancer mortality among insulation workers—approximately 20 percent. The fivefold relative excess for asbestos exposure alone remains in the small number of nonsmoking workers, but lung cancers are not commonly seen because the baseline rate is so low in nonsmokers.^{6,7}

Mesothelioma of the pleura or of the peritoneum accounts for up to 10 percent of deaths in exposed working populations.⁷ Latency from onset of exposure most commonly is 30 to 40 years. Mesothelioma has no causes established other than asbestos exposure and is not influenced by cigarette smoking.

Cancer of the larynx, colon, esophagus, and stomach have been observed to increase in asbestos-exposed cohorts, with reported increases in the range of 1.5 to two times controls in the largest studies.⁷ The causal role of asbestos for malignancy at these sites is less uniformly acknowledged than for the lung, pleura, and peritoneum.

CLINICAL EVALUATION

The key to evaluating asbestos-related disease lies in understanding exposure. Although no amount of asbestos exposure may be deemed safe from a carcinogenesis point of view, lower amounts of exposure, as in offices or schools, are less likely to produce disease. This especially is true for pleuropulmonary fibrosis.

Occupational histories should focus on the intensity and time of exposure. Indirect exposures to workers such as electricians, sheet-metal workers, and welders have been associated with radiographic abnormalities characteristic of asbestos exposure,⁸ as well as excess mortality from mesothelioma and cancers of the lung and colon.⁹ Questions, therefore, should attempt to depict the workplace around the patient, and what other types of workers often were present. Shipyards and construction sites often have workers from many trades in close proximity. Since family exposures from dusty work clothes have

caused both fibrotic disease and malignancy in asbestos workers' wives and children, such home exposures are important to note.¹⁰ Exposures to asbestos in schools, home basements, and buildings represent a poorly quantified source of exposure without well-studied health outcomes. Although there has been disagreement about the levels of risk posed by such situations, the Environmental Protection Agency (EPA) has required all local education agencies to identify asbestos-containing materials in schools, and to control the release of fibers.^{11,12} Such efforts are directed mainly at reducing cancer risks, since except for some maintenance workers, risks of benign fibrosis are likely to be very low.¹³

Symptoms of asbestos-related disease are the symptoms of restrictive pulmonary fibrosis. When advanced, this fibrosis may be clinically detectable in the lung parenchyma by irregular opacities on chest x-ray, usually in the lower lobes, and with substantial progression, by restrictive changes on lung function tests, or a decrease in the diffusing capacity. Pleural fibrosis may manifest either as discrete plaques on chest x-ray or more diffuse thickening of the pleural lining, often best demonstrated on oblique views. With increasing time from exposure, this pleural fibrosis may become calcified, making it easier to detect on chest x-ray. Bilateral thickening of the pleura has a high predictive value for past asbestos exposure.¹⁴ Depending upon their shape and the presence of calcifications, pleural changes may be almost pathognomonic for asbestos exposure. Physical examination in an advanced stage may reveal limited chest expansion, inspiratory crackles in the lung bases, and clubbing.

Decreased lung volumes, characteristic of restriction, and an impaired diffusing capacity are the classic pulmonary function changes of asbestosis. However, other forms of pulmonary fibrosis may cause similar patterns of abnormalities, and interpretation of pulmonary function tests (PFT) often is complicated by smoking-induced changes of obstruction.¹⁵

BIOPSY MATERIAL

Transthoracic and transbronchial lung biopsy usually are not successful in obtaining enough tissue for histologic diagnosis of asbestosis. In addition, the lesions of asbestosis may be irregularly distributed, causing the diagnosis to be missed unless tissue sampling is directed; however, unless ruling out treatable disease such as sarcoidosis, open biopsy rarely is warranted.¹⁶ When tissue is obtained incidentally, as it is during workup or resection of a pulmonary mass lesion, the clinician should discuss concern for the presence of asbestosis with the pathologist, aiding in the search for pathologic

evidence of asbestosis. Asbestos bodies may be difficult or impossible to demonstrate, especially on routine tissue sections,¹⁷ and chrysotile, the most prevalent form of asbestos, is least likely to produce large numbers of the coated bodies.

COMMON CLINICAL SCENARIOS

1. For the Apparently Healthy Individual with Exposure. The clinician must consider whether asbestos truly has been present, and whether it has been respirable if present. Although no amount of asbestos exposure can be considered safe from a carcinogenic risk perspective, less is better than more, and a lifetime cumulative exposure threshold of 10 to 25 "fiber-years" for clinically significant asbestosis has been suggested.¹⁸ Occupational exposures usually are higher (in fiber concentrations in the air) than nonoccupational environmental exposures. Assess the number of hours per day, days per week, weeks per year, and years that a person has had an exposure. Were there any mitigating factors, such as ventilation, wetting, enclosure, or respirators? Were the respirators maintained and fit-tested? Were OSHA and EPA regulations adhered to on the job?

Based on the cumulative threshold, residential exposure, such as that from basement insulation, rarely will be of concern vis-a-vis asbestosis, but cancer risk remains a concern.

From the clinical point of view, one needs to assess whether the absence of disease in this case is meaningful, or is the latency too short to expect disease? Ten years of heavy exposure is likely to cause disease, but not before a latency of 20 to 30 years.

If the latency and exposure is sufficient to permit detectable abnormalities, one needs to assess whether or not it is truly absent. An asymptomatic person may have irregular opacities on chest x-ray. Spirometry may be normal in the face of an impaired diffusing capacity. Pleural thickening may be visible only if oblique films are taken. Frequently, mild disease will be seen as an indicator of exposure, but without apparent impairment. If an individual truly has had significant exposure, he is likely to be at some increased risk for future malignancy whether or not any disease is detectable. The quantitation of this risk and its dose-response relationship are the basis for much continued discussion.¹⁹

Counseling such individuals is difficult. If the patient has not had occupational exposures for extended periods, especially prior to the 1970s, individual risks of developing an asbestos-related cancer will not be very great. This is not to say that the risks for lung cancer in a population of similarly exposed people would not be elevated. The most important recommendations include smoking cessa-

tion to reduce the substantial carcinogenic risks, and minimization of future exposure.

2. For the Individual with Fibrotic Disease. Goals for this patient will be similar to that for any chronic and incurable lung condition, including prevention and early treatment of superinfection. Future exposure should be minimized, although it often is not realistic for a middle-aged person to change occupations. Smoking cessation is of even greater benefit than in other lung conditions because of the multiplicative interaction with asbestos exposure in effecting carcinogenesis. Controlled chemoprevention trials of anticarcinogens such as retinoids are being performed.

Compensation will be available to many such individuals, and if the physician suspects a potentially work-related illness like asbestosis or a malignancy, the patient needs to be so advised, as he may have a limited amount of time to initiate a claim.

3. For the Physician Ascertaining Whether a Case of Pulmonary Fibrosis or Lung Cancer is Related to Asbestos. Exposure history is very im-

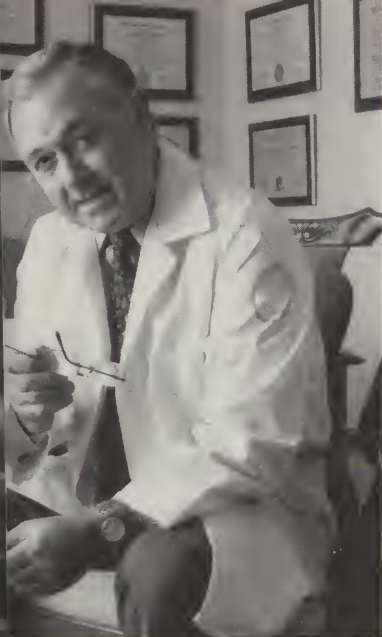
portant. It often is necessary to review previous exposures or jobs. In the case of lung cancer, the presence of pleuropulmonary fibrosis can be a rough indicator of previous asbestos exposure, although the x-ray and other modalities have limited sensitivity for its detection when compared to expert tissue examination.^{20,21} The fact that cigarette smoking is a powerful determinant of lung cancer incidence does not discount the effects of asbestos, and in the presence of both exposures, many tumors will be attributable to both exposures.

CONCLUSION

Since 1946, five successively lower occupational standards for asbestos exposure have been promulgated in the United States. It is hoped that the current standard of 0.2 fibers/cc of air (200 fibers/liter) will reduce risks to an acceptable level. Unfortunately, the latency of asbestos-induced health effects is such that New Jersey clinicians will be confronting disease from previous exposures for many years. ■

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Indoor Air Pollution

PAUL J. LIOY, PhD
ELAINE PANITZ, MD

The presence of airborne contaminants in the indoor environment is not a new phenomenon. The magnitude and scope of the problem, however, have changed in the last decade to the point where health effects and/or symptoms have been observed in both residences and office buildings (tight building syndrome). Because of the extent to which indoor pollution has become a problem, the physician must be aware of the situations that could lead to high exposures and related patient complaints, e.g. involuntary smoking and infant illness, and neurophysiological symptoms to formaldehyde. The reasons for the accumulation of high concentrations of some pollutants and the introduction of new pollutants primarily are twofold: the reduced ventilation and increased insulation in buildings to improve energy efficiency, and the use of synthetics in building materials and furnishings.¹ To further aggravate the situation, it has been noted that people in the United States spend more than

70 percent of their time indoors with employed adults averaging less than 45 minutes outdoors.² Those individuals spending the greatest time indoors within private residences are potentially the most susceptible groups, i.e. the old, infants, the infirm.³

Physicians are involved with patients affected directly by acute responses to indoor chemical exposures with the frequency being single or multiple in nature. In the following sections, we will outline the nature of major compounds and compound classes of concern and their sources. We also will present a case study describing the clinical features of the sick building syndrome. Finally, we present a checklist to assist physicians in evaluating patients with suspected indoor pollution-related symptoms.

INDOOR POLLUTANTS AND EXPOSURE

The indoor pollution problem is complicated by the extensive number of contaminants present; many of these are associated directly with indoor sources. At times, especially during the warmer seasons, outdoor pollutants also will penetrate indoors. A list of the more common indoor contami-

Requests for reprints may be addressed to Dr. Liroy, Division of Exposure, Measurement, and Assessment, Department of Environmental and Community Medicine, UMDNJ-Robert Wood Johnson Medical School, Piscataway, NJ 08854.

nants is found in the Table. These materials are not present in all homes; however, the sources are quite common. Thus, there is a possibility of having individuals exposed to one or more of these substances on a regular basis.

Volatile Organics. A major group of chemicals is the volatile organics which accumulate indoors from various sources including: solvents, e.g. chlorinated hydrocarbons; personal toiletries; synthetic fibers, e.g. carpeting; drycleaned clothes; glues and epoxy; and particle board. Single or multiple compounds will be emitted from a given source.⁴

The different classes of volatile organic compounds manifest their effects in four major categories: 1) odors and their psychophysical effects (such as sensory irritation); 2) irritation (respiratory tract and mucous membranes) and other morbidity associated with systemic toxicity; 3) menstrual dysfunction and genotoxicity; and 4) carcinogenicity. Volatile organics are considered to be one of the main groups of compounds associated with the tight building syndrome.

At present, major research programs are being conducted to characterize volatile organic emissions from consumer products. The results should provide fingerprints and/or unique tracers to identify a source and identify those compounds which are known to be of importance to public health.⁵

A research project directed at the characterization of indoor air is the total exposure assessment methodology (TEAM) study performed by the Environmental Protection Agency (EPA) which is examining population exposure to volatile organics in a number of different locales.⁶

Combustion Products. The substances emitted from combustion sources are a complex mixture of gaseous and particulate species. For example, nitrogen dioxide, an irritant for the upper airways of the lung and benzo(a)pyrene, a known carcinogen, can be emitted simultaneously during combustion. Except in the extreme circumstances, such as a clogged furnace flue or a poorly operated fireplace, most of the substances commonly emitted within a home or office are from unvented sources; some sources are intermittent seasonal use devices, such as unvented kerosene space heaters, while the typical sources are cigarettes and/or a gas range. Other indoor combustion sources are vented coal burning and wood burning stoves.

Combustion products vary from residence to residence, depending upon the lifestyle of the inhabitants. In Figure 1, the levels of benzo(a)pyrene measured in inhalable particulate matter of $\leq 10 \mu$ in diameter were found indoors for ten homes and were found simultaneously outdoors at three sites.¹⁰ The data indicate a wide variation in exposures with

some homes showing higher indoor levels and others having levels similar to the outdoor values. The annotations on Figure 1 show the highest levels were associated with a specific indoor personal activity, such as smoking, paint removal, or coal stove use.

Side-Stream Tobacco Smoke. In the case of cigarettes and other tobacco products, the exposure to inhabitants, apart from the smoker, is from the generation of side-stream tobacco smoke. Studies have linked increases in childhood illnesses and other cardiorespiratory illnesses with situations where the child was exposed to side-stream smoke and, thereby, participated in passive smoking.^{8,9} Previous studies have shown that exposures to active and passive smoke contaminants are different both in concentration and composition.⁷ The compounds can be more toxic or carcinogenic in side-stream smoke. However, the contaminant concentrations will be much higher in mainstream smoke.

Formaldehyde and Asbestos. Formaldehyde and asbestos are special problems associated with home insulation. The former began in the mid-1970s when the general population was concerned seriously with energy conservation.^{5,6} At that time, homeowners had urea-formaldehyde foam blown into walls for added insulation, and the unbinded colorless formaldehyde gas was released into the home. Since then, the practice has declined substantially. Today, formaldehyde is released primarily from common household and office furnishings, carbonless copiers, cigarette smoke, and carpets. The range of concentrations is shown in the Table for mobile homes and homes with wallboard. Formaldehyde is soluble in water and, thus, can irritate the mucous membrane of the eye and upper respiratory system. Formaldehyde produces nasal cancer in animals, but further studies are necessary to determine carcinogenicity in man.

Asbestos is another contaminant released from insulation, but it usually is of concern because of flaking and rupturing of pipe and wall insulation in older public buildings and private homes. At present, asbestos is removed or encapsulated, depending upon the degree of contamination. The etiology of the asbestos-related diseases (asbestosis and lung cancer) is long term in nature. Measured indoor and outdoor levels of asbestos usually average 0.004 filters/cc and five times those levels are found in schools with asbestos insulation problems. At these levels, abnormalities will not be observable in a clinician's chest x-ray; however, there is a risk for malignant diseases.

Radon. Actual radon levels observed indoors are dependent upon the ability of radon to penetrate from surrounding soil or from building materials. The infiltration primarily is by diffusion caused by

Table. Typical indoor pollutant concentrations.*

Pollutants of Concern	Concentration (Sampling Time)	Location	Types of Sources
Carbon monoxide, CO	2.5-28 ppm	Offices, restaurants, bars, arenas	Combustion equipment, engines, stoves, faulty heating systems
	3.1-7.8 ppm (seasonal averages of 12 h samples)	Kitchen of homes with gas stoves	Combustion, gas stoves, water heaters, dryers
Nitrogen dioxide, NO₂	0.005-0.317 ppm (1 wk)	English homes with gas cookers,	Combustion, gas stoves, water heaters, dryers, cigarettes
	0.005-0.11 ppm (24 h)	American homes with gas stoves,	
	<0.06 ppm (24 h)	American homes with electric stoves	
Respirable particles, RP	100-700 µg/m ³ (8-50 min)	Restaurants, sports arenas, residences with smoking and without smoking, residences	Stoves, fireplaces, cigarettes, condensation of vapors, sprays, combustion cooking
	20-60 µg/m ³ (1-42 min)		
	10-70 µg/m ³ (24 h)		
Total suspended particles, TSP	39-66 µg/m ³ (averages of 12 h samples; 26-72% of outdoor concentrations)	Homes, public buildings	Dust, resuspended particles, sprays, respirable particles
	2.7-79.4 µg/m ³ (48 h)		
Asbestos	0-100 ng/m ³ (0-2 x 10 ⁴ fibers/m ³) (5 min to 10 h)	Normal activities, during maintenance	Fire retardants, thermal tiles
	20 x 10 ⁶ fibers/m ³		
Organic compounds	Varies depending upon compound		Smoke, paints, solvents, cosmetics
Formaldehyde, HCHO	60-1673 ppb (1 h; 463 ppb average for all measurements)	Homes with chipboard walls, mobile homes	Particle board, furnishings, product binder insulation, tobacco smoke
	30-1770 ppb (35-60 min)		
Ozone, O₃	<0.002-0.068 ppm (40 min to 2 h)	Photocopying machine, homes with electrostatic air cleaners	Photocopying, (primary outdoor outdoor filtration)
	<0.002-0.018 ppm (30 min)		
Radon	0.01 to 80 pCi/l (various)	House in U.S. including New Jersey and Pennsylvania, house on Florida reclaimed phosphate land	Building construction material, contaminated soil, natural crustal material
	<25-34 pCi/l (averages of 3-to-6 min samples)		
Benzo(a)pyrene	7.1-21.0 ng/m ³ (2-4 h)	Sports arena, homes in New Jersey	Combustion, cigarette smoke, stoves, cooking
	0.1-9.0 ng/m ³ (24 h)		
Carbon dioxide, CO₂	0.086% (5 min)	Lecture hall, school room, nuclear submarines	Metabolic activity, combustion
	0.06-0.25%		
	0.9% (continuous measurements for 8 weeks)		
Table particles	20-700 CFP/m ³ (averages of 10-minute samples taken every 40 minutes)	Schools, hospitals, residences	Infections, fungi, molds, spores

*Adapted from Wadden RA, et al.: *Indoor Air Pollution*.³

pressure/temperature differences between indoors and outdoors, and changes in wind speed.¹¹ No unequivocal estimates of exposure can be made; however, there are major areas of New Jersey in which radon testing has been done, and maps have been developed to illustrate the geographical extent of exposure.¹² A range of encountered radon levels is found in the Table. Some homes in New Jersey have been found to be above the occupational exposure limit for radon and its progenies.¹³ The risk estimates for cancer made by various organizations indicate that radon could be associated with a major fraction (20 percent) of the nonsmoking-related lung cancer.¹⁴

Viable Particles. In addition to the exposures related to chemical contaminants indoors, there are exposures to viable materials, such as mites, bacteria, viruses, and molds. These are common materials which have similar and/or equivalent mechanisms of dispersal and exposure to the chemical contaminants. In a clinical setting, these are manifested by infections or by hypersensitivity, e.g. sinus, pneumonitis, Legionnaire's disease, *Aspergillus* infections. For some of these situations, the physician requires resources to equate observed health effects

and symptoms with the sources and concentrations of specific viable particles.

CASE REPORT

A 40-year-old white, female, nonsmoker was a long-term employee in a large New Jersey corporation. Her past medical history was significant for occasional "sinus trouble." In October, she and 400 other employees began work in a new office building. The staff complained that the office air seemed stale.

Within a week, the patient noticed burning of the eyes, redness of her face and anterior neck, and a postnasal drip while in the building. After several weeks, the patient complained of sore throat, hoarseness, chest heaviness, and palpitations at the end of each work day. Her symptoms were most apparent when she worked overtime or failed to leave the building at lunch time. She developed "soreness" in the forehead area and complained of headaches that were poorly responsive to over-the-counter analgesics. Her lips and hands were chapping, and she no longer could tolerate wearing her contact lenses. Her nose burned and itched continually, and she was out of work for "colds" three times in four weeks. During

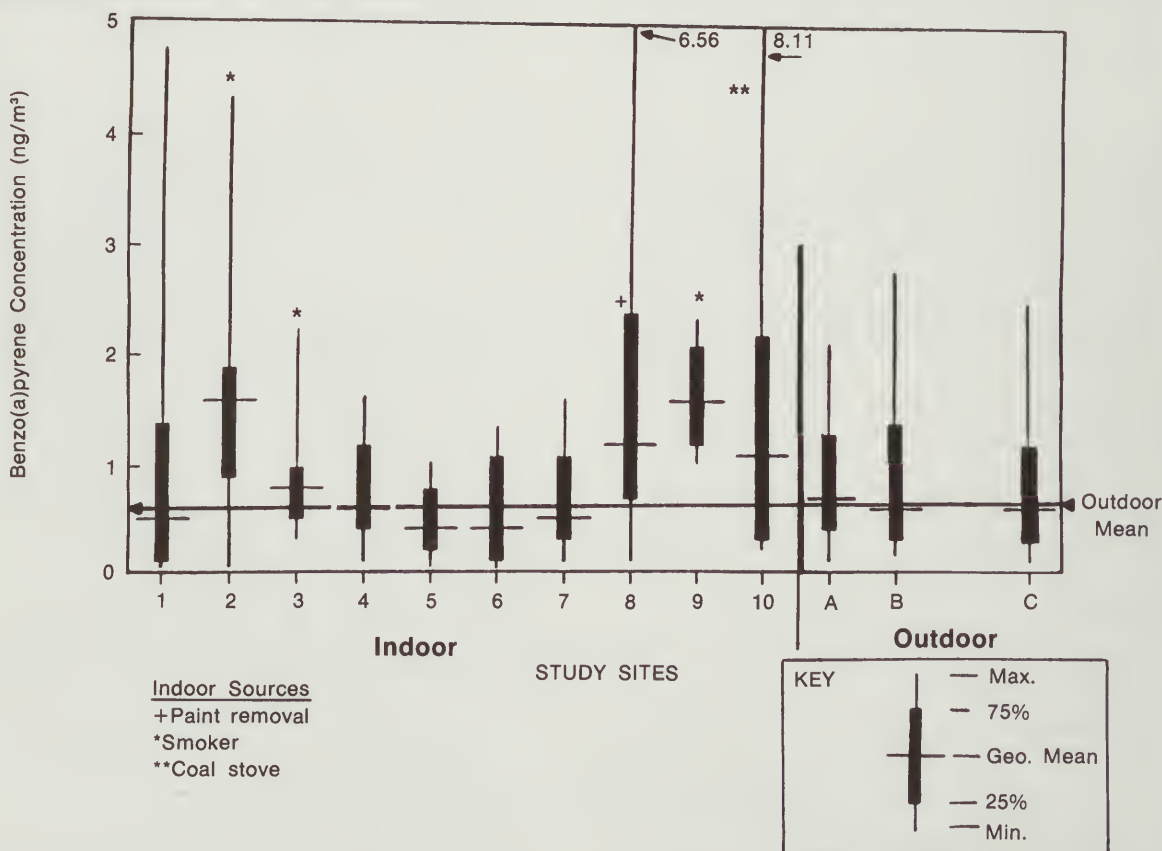


Figure 1. Benzo(a)pyrene concentrations for indoor and outdoor sites from the total human environmental exposure study, January 29 to February 12, 1987.*

*Adapted from Liou PJ, et al.: The total human environmental exposure study to benzo(a)pyrene. *Arch Envir Health*.¹⁰

For each question, please respond by checking yes or no in the adjacent columns:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1. Persistent symptoms which include one or more of the following: burning or sore eyes, sinus irritation, dry or sore throat, headaches, difficulty in breathing, difficulty in sleeping, coughing, dizziness, fatigue, nausea, diarrhea or unusual stool, chest or abdominal pain, menstrual irregularity.
<input type="checkbox"/>	<input type="checkbox"/>	2. Above symptoms are not related to cold, flu, or other common illnesses.
<input type="checkbox"/>	<input type="checkbox"/>	3. Some of above symptoms are associated with eye or sinus infections.
<input type="checkbox"/>	<input type="checkbox"/>	4. Similar symptoms were reported among your co-workers (if your symptoms occur at work), or among other members of your family (if your symptoms occur at home).
<input type="checkbox"/>	<input type="checkbox"/>	5. Symptoms are most severe after increased time at work, i.e. overtime, no breaks, or lunch hour, or symptoms are most severe in the family member who spends most time at home—infants, homemakers, elderly.
<input type="checkbox"/>	<input type="checkbox"/>	6. Symptoms are less severe when home or office receives significant increases of ventilation over a period of several weeks.
<input type="checkbox"/>	<input type="checkbox"/>	7. If you live in a mobile home park, health symptoms also are common among your neighbors.
<input type="checkbox"/>	<input type="checkbox"/>	8. Symptoms become less severe when away from home or office for a period of time, longer periods showing a marked improvement.
<input type="checkbox"/>	<input type="checkbox"/>	9. Have been evaluated by your doctor, or hospitalized, for diagnostic tests which were negative or inclusive.
<input type="checkbox"/>	<input type="checkbox"/>	10. Onset of symptoms associated with: <ul style="list-style-type: none"> a) moving into a recently purchased house. b) moving into a mobile home. c) working in a new or newly renovated office. d) remodeling of a house. e) insulating a home with urea-formaldehyde foam. f) implementing energy conservation efforts to significantly reduce heat loss. g) purchasing particle board furniture or resin-treated upholstery. h) installing new kitchen or bathroom cabinets.
<input type="checkbox"/>	<input type="checkbox"/>	11. Symptoms become more severe during warm humid weather, or when heating season begins, or when air conditioning season begins, or when humidifier is used.
<input type="checkbox"/>	<input type="checkbox"/>	12. Symptoms become less severe on dry winter days, or when house is ventilated by open windows.

Figure 2. Building-related illness checklist.*
*Adapted from Godish T: Recognition of building-related illness.¹⁷

her third "cold," six weeks after beginning work in the new building, she saw her family physician.

On physical examination she was afebrile, mildly hypertensive (150/95), tachycardiac (105-110), and showed evidence of conjunctival, nasal, and pharyngeal irritation. There was a small amount of clear posterior pharyngeal drainage. Her face was slightly erythematous and puffy, especially about the eyes and nose. The remainder of her examination was unremarkable. Complete blood count, automated chemistry screening, erythrocyte sedimentation rate, urinalysis, chest x-ray, spirometry, and sinus x-rays were normal. Electrocardiogram revealed only sinus tachycardia. Her physician felt that she was allergic to something in her environment. He prescribed Actifed® one tablet three times daily and erythromycin 250 mg four times daily for one week.

With medication she improved, but symptoms recurred on return to work: her menstrual periods had tapered off and became almost nonexistent, she felt lightheaded and nauseated, she had difficulty concentrating on her work, she had become very emotional, and she was continually exhausted.

The family physician reviewed the patient's symptoms for the past four months, and noted the relationship of symptoms to her work in the new building. She was assigned temporarily to a branch office and within several days, the patient noted decreased eye and respiratory irritation. After a time, her menstrual period returned, her emotional lability gradually improved, and she experienced improved ability to think and concentrate. Blood pressure and pulse returned to normal.

Similar complaints from the patient's coworkers were the impetus for a confidential health questionnaire. There were 347 (90 percent) respondents in the headquarters building, and 230 (76 percent) respondents from branch offices. Frequent or daily eye irritation was reported three times more often and skin irritation almost five times more often, in the headquarters building, compared to the branch offices. Symptoms of upper and lower respiratory tract irritation and illness, and central nervous system symptoms were reported almost three times more often in the headquarters building. Menstrual irregularity was reported more than four times more

often among women in the headquarters building, compared to women in the branch offices.

The headquarters building had been constructed within the past two years; approximately 80,000 square feet of wall-to-wall nylon carpeting had been installed with a rug adhesive, and sprayed with an ammonium chloride anti-static agent, the walls had been painted with latex, alkyd, and enamel paints, desks were laminated pressed particle board (70 percent urea formaldehyde), and the office design was open. Desks held bond paper, carbonless copy paper forms, and typewriter correction fluids. Employee smoking had been prohibited.

Volatile organic hydrocarbons consistently were nondetectable (less than 0.1 ppm) by chemical detector tube analysis, although continuous gas chromatographic results ranged from 0.25 to 3.50 ppm (background levels usually 0.20-0.40 ppm). Formaldehyde air levels were 0.10-0.20 ppm, which are one-tenth the occupational guideline (normal: 1 ppm). Acetaldehyde levels averaged 20 ppm (normal 100 ppm). Sulfur dioxide and oxides of nitrogen levels were nondetectable. Carbon monoxide levels were 3 to 4 ppm (recommended levels are less than 35 ppm). Carbon dioxide levels averaged 890 ppm, with levels as high as 1300 ppm (simultaneous outdoor levels averaged 350 ppm). Airborne bacterial and fungal counts ranged from nil to 1.112 colonies/m³. Airborne fiberglass levels were nondetectable. Nuisance dust levels were very low. Testing of

furniture, fixtures, paint, carpeting, and other materials failed to reveal unusual or excessive chemical off-gassing. Water testing from fountains and kitchenettes was negative for coliforms.

Evaluation of the heating, ventilation, and air conditioning system revealed that the work areas were receiving fewer than 4 air changes per person occupancy per hour (more than 15 air changes per hour recommended).

No airborne chemical, physical, or biologic agents were detected in amounts that exceeded occupational standards. However, the values for volatile organics, carbon dioxide, and formaldehyde were present in levels at least three times greater than outdoor air. Since these indoor pollutants accumulated, the results support the finding of inadequate air changes per person occupancy per hour. The constellation of employee symptoms, commonly referred to as tight building syndrome^{15,16} appears to have resulted from accumulation of common indoor irritants from furniture outgassing, and the diffusion of gases from the adhesives used on carpets in the offices.

A patient questionnaire (Figure 2) has been designed to assist the physician in evaluating a patient suspected of suffering from building-related illness. Recognition of the syndrome will allow efforts to be directed at improved ventilation, and, if necessary, assist you in recommending removal of your patient from the offending building. ■

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Governor Thomas H. Kean (right) signs bill into law as New Jersey State Medical Underwriter, Inc. President Peter Sweetland (left) and Chairman Henry J. Mineur, M.D. (center) look on.

Chemical and Dust-Related Diseases

MARTHA STANBURY, MPH
KENNETH D. ROSENMAN, MD

How many people in New Jersey become ill from chemical or dust-related diseases? Under what circumstances are these people being exposed to chemicals and dust? Will additional individuals become ill from the same exposures? What actions should be taken to prevent additional illnesses? If you feel you are guessing when you answer these questions, you are doing what the experts in this field often do. The surveillance programs needed to identify who and how individuals are becoming sick from chemicals and dusts are just in their infancy.

During the 1900s, surveillance systems have been a basic tenet of controlling and preventing communicable disease. No such surveillance systems currently exist for chemical or dust-related diseases despite the great concern and fear about the health effects of chemicals. This problem is not unique to New Jersey; however, it reflects the absence of any comprehensive surveillance program at either the state or national level.¹ State health departments can and should play a critical role in chemical and dust-disease surveillance. The departments can provide centralized data collection systems and re-

sources for public health interventions designed to eliminate exposures to causative agents and they can assist local physicians in diagnosing and treating these conditions by providing consultative services with preventive medicine experts, evaluations of patients' chemical exposures at work and in the community, and continuing medical education programs.

The New Jersey State Department of Health (NJDOH) has initiated a number of programs to assess the magnitude of the health consequences of exposure to chemicals and dusts. This paper describes the components of current surveillance programs which are based on secondary data sources, including hospital and laboratory reporting and vital records. Deficiencies in current surveillance activity and the need for additional involvement of physicians are discussed. The usefulness of the information collected for diagnosis and management of individual patients is explored. A case report is provided that illustrates the importance of physician involvement in surveillance activities for the prevention and control of chemical and dust-related disease.

SURVEILLANCE AT NJDOH

Hospital Reporting. Funded since 1984 by the National Institute for Occupational Safety and

Requests for reprints may be addressed to Ms. Stanbury, Division of Occupational and Environmental Health, New Jersey State Department of Health, CN 360, Trenton, NJ 08625.

Table 1. Results of medical record review of patients reported by hospitals to have the discharge diagnosis silicosis.

Medical Record Review	Cases	%
Diagnosis of silicosis confirmed by review of x-ray and/or biopsy report	83	54
Diagnosis of silicosis confirmed by review of x-ray report	38	25
No evidence in records to confirm or negate diagnosis of silicosis	3	2
X-ray or medical records review either indicated normal x-ray or linear opacities	29*	19
Total	153	100

*Thirteen of the individuals with linear opacities on their x-ray were considered more likely to have asbestosis.

Health (NIOSH), NJDOH has used hospital reports from the DRG system to conduct a pilot surveillance project for silicosis. Patients identified from the DRG system with a discharge diagnosis of silicosis are interviewed to determine the names of workplaces where exposure to silica took place, and to obtain consent to review medical records. Medical records of consenting individuals, including chest x-rays, are examined in order to confirm the case diagnosis and to assess the severity of disease.

Information also is gathered on current workplace users of, and employee exposures to, silica from industrial hygiene data provided by the Occupational Safety and Health Administration (OSHA) and the Mine Safety and Health Administration. Current silica users then are visited by NJDOH industrial hygienists who conduct walkthrough evaluations and interviews with employers and employees about exposures, medical surveillance programs, and hazard control. Written reports with recommendations for hazard control are issued and sent to the treating physicians.

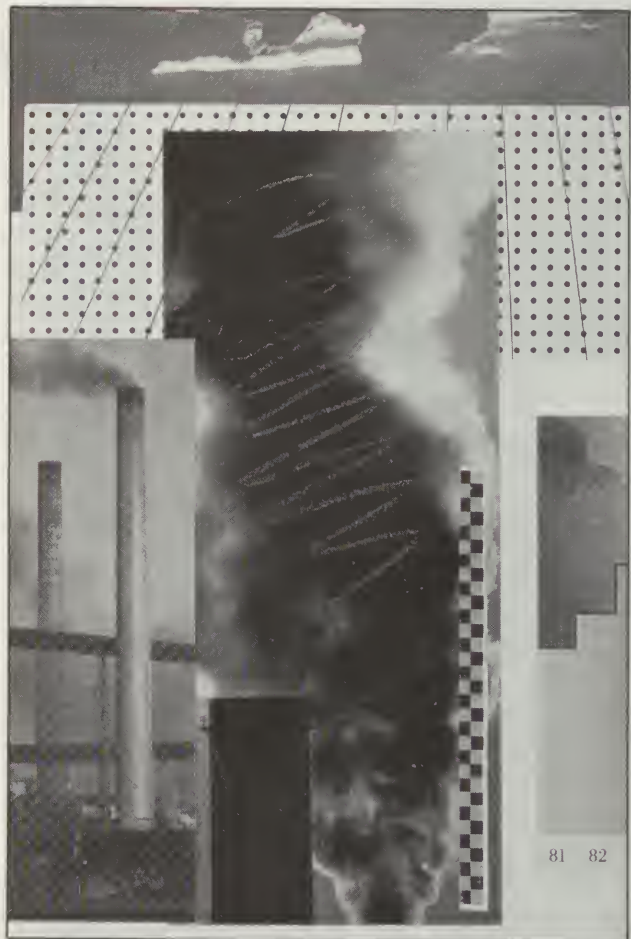
Between 1979 and 1987, 529 individuals diagnosed with silicosis have been identified. A review of their work histories indicated that 94 (18 percent) were considered more likely to have had coal worker's pneumoconiosis and 10 (3 percent) were considered to be coding errors by the hospitals. One hundred fifty-three medical records have been reviewed. Evidence for the diagnosis of silicosis was found in 121 (79 percent) of the medical records. Of the 29 (19 percent) cases in which silicosis could be ruled

out, asbestosis was considered to be the most likely disease in 13 (9 percent) individuals (Table 1). Medical screenings of all employees at 2 of the 28 workplaces followed up resulted in the diagnosis of 27 additional silicosis cases by health department physicians.

Of the 142 workplaces identified from patient interviews, 68 workplaces have been identified as current silica users. Twenty-eight workplaces have been evaluated by NJDOH industrial hygienists. The most common problems identified by the industrial hygienists have been inadequate ventilation, inadequate workplace practices for dust cleanup, use of the wrong respirator, and the absence of proper medical surveillance for current employees.

Employer cooperation in following NJDOH recommendations has been good. Recontact with 12 of the employers initially visited has revealed that 8 employers have implemented recommendations made by NJDOH. NJDOH is continuing to work with employers to ensure that employees are adequately protected from silica dust.²

Hospital reports also have been used for surveillance of other lung diseases and poisoning related to chemicals or dusts. In 1985, a total of 2,169 individ-



uals were reported by hospitals to have a chemical or dust-related disease. One thousand one hundred nineteen individuals were reported with chronic occupational lung disease, i.e. coal worker's pneumoconiosis, asbestosis, silicosis, other pneumoconiosis; 243 individuals with an acute lung condition; and 807 persons with a chemical poisoning (Table 2). The number of reports is an underestimate of the true number of cases because many people with these conditions do not enter a hospital. Identification of individuals and their workplaces was facilitated in October 1985 by a state regulation requiring hospitals to report to NJDOH names and medical record numbers of patients with the discharge diagnoses listed in Table 2. Activities similar to those for silicosis currently are being initiated for some of the acute lung conditions and poisonings.

Laboratory Reporting. In October 1985, regulations were adopted that require all clinical labora-

tories to report to NJDOH elevated blood and urine levels in adults of four heavy metals: lead (blood levels $\geq 25 \mu\text{g/dl}$, urine levels $\geq 80 \mu\text{g/l}$); mercury (blood levels $\geq 2.8 \mu\text{g/dl}$, urine levels $\geq 20 \mu\text{g/l}$); arsenic (blood levels $\geq .07 \mu\text{g/dl}$, urine levels $\geq 100 \mu\text{g/l}$); and cadmium (blood levels $\geq 5 \mu\text{g/l}$, urine levels $\geq 10 \mu\text{g/l}$). As of December 1987, a total of 2,629 blood and urine reports have been received. The majority of reports are for lead, which is the only metal for which federal OSHA regulations require biological monitoring. The 2,135 blood lead reports represent 1,150 different individuals. Sixty-seven percent of the blood lead reports have been between $25 \mu\text{g/dl}$ and $39 \mu\text{g/dl}$, 30 percent have been between $40 \mu\text{g/dl}$ and $69 \mu\text{g/dl}$, and 3 percent have been above $70 \mu\text{g/dl}$ (Table 3).

One hundred seventeen lead-using workplaces have been identified from laboratory reports and contact with reported individuals. Adults reported

Table 2. Hospital reports of pulmonary and nonpulmonary diseases from dusts and chemicals, New Jersey residents, 1985.

Disease	Cases
Extrinsic allergic alveolitis	40
Coal worker's pneumoconiosis	228
Asbestosis	717
Silicosis	82
Pneumoconiosis due to other inorganic dust	8
Pneumonopathy, due to inhalation of other dust	6
Pneumoconiosis, unspecified	78
Respiratory conditions due to chemical fumes and vapors	127
Pneumonitis due to solids or liquids	45
Respiratory conditions due to other and unspecified external agents	31
Toxic effects of petroleum products	39
Toxic effects of solvents other than petroleum-based	55
Toxic effects of corrosive aromatics, acids, and caustic alkalis	128
Poisoning due to organic lead compounds	0
Poisoning due to other metals	43
Poisoning due to gases, fumes, or vapors (excluding carbon monoxide)	413
Poisoning due to pesticides	129
Total	2,169

Table 3. Number of adults with laboratory reports of elevated heavy metals, October 1985 to December 1987.

Lead		
Blood Lead		
Reportable if $\geq 25 \mu\text{g/dl}$	Cases	%
25-39 $\mu\text{g/dl}$	774	67
40-69 $\mu\text{g/dl}$	342	30
70+ $\mu\text{g/dl}$	<u>34</u>	<u>3</u>
Total	1150	100
Urine Lead		
Reportable if $\geq 80 \mu\text{g/L}$	167	
Other Heavy Metals		
Urine and Blood Results Combined		
		Cases
Mercury		191
Reportable blood level $\geq 2.8 \mu\text{g/dl}$		
Reportable urine level $\geq 20 \mu\text{g/L}$		
Arsenic		26
Reportable blood level $\geq 0.07 \mu\text{g/dl}$		
Reportable urine level $\geq 100 \mu\text{g/L}$		
Cadmium		17
Reportable blood level $\geq 5 \mu\text{g/L}$		
Reportable urine level $\geq 10 \mu\text{g/L}$		

Table 4. Mortality from dust-related lung diseases in New Jersey, 1979-1985.

Disease	Cause of Death		Total
	Underlying Cause	Contributing Cause	
Coal Worker's Pneumoconiosis	59	79	138
Asbestosis	77	264	341
Silicosis	40	39	79
Pneumoconiosis due to other inorganic dust	6	3	9
Pneumonopathy due to inhalation of other dust	2	0	2
Pneumoconiosis, unspecified	42	55	97
Total	226	440	666

with elevated blood lead levels receive a letter containing information about the health effects of lead and a followup interview to determine the source of exposure and information about medical care.

The protocol for industrial hygiene followup at lead-using workplaces is similar to that for silicosis. As of December 1987, 19 lead- and 5 mercury-using workplaces have had some level of industrial hygiene intervention. As with silica workplaces, inadequate ventilation, work practices, housekeeping, and respirator use have been found to be the most common problems. In the case of a secondary smelter where 16 workers had blood lead levels ranging from 32 $\mu\text{g}/\text{dl}$ to 72 $\mu\text{g}/\text{dl}$, dust was swept with dry brooms and respirators were used inconsistently. Following industrial hygiene evaluation by the NJDOH, implementation of better control measures and respirator use resulted in dramatically lowered blood lead levels.

Vital Records. NJDOH uses death certificates, birth records, and cancer registry data for trend surveillance and to generate hypotheses about the associations between suspected exposures to dusts or chemicals and disease outcomes.

Death certificates contain underlying and contributing causes of death that are coded and computerized. For the years 1979 to 1985, dust diseases of the lung caused 226 deaths in New Jersey and contributed to deaths in 440 additional cases (Table 4). New Jersey will begin coding occupational information of the deceased on death certificates and that of parents on birth certificates in the next year, so that cause-specific disease patterns by occupation and industry can be tracked. Other states already conduct this kind of surveillance activity.⁴

The New Jersey Cancer Registry is one of the nation's Surveillance Epidemiology and End Results (SEER) registries and histologically confirms all incident cancer cases in the state. A study to identify

associations between occupations of individuals with cancer and specific cancer outcomes has been carried out.⁵ Findings from this study include increased lung cancer and mesothelioma among workers in many industries which use asbestos; increased bladder cancer among workers in clothing manufacturing; and leukemia and lymphoma among chemical-exposed workers.

Physician Reporting. Although most of the surveillance programs at NJDOH do not rely on direct physician reporting to the health department, they are dependent on involvement of physicians in the recognition of the chemical or dust cause of a patient's symptoms and the accurate completion of a hospital discharge summary, birth, or death certificate. The importance of increased physician education and awareness regarding diagnosis of chemical or dust-related disorders is recognized.^{6,7}

NIOSH, the branch of the Centers of Disease Control responsible for research in chemical and dust-related diseases at work, has initiated several activities. NIOSH has been involved in a variety of physician education projects, and it also has developed standardized diagnostic criteria and epidemiologic case definitions for certain conditions. In addition, NIOSH recently funded ten state health departments, including New Jersey, to develop physician reporting systems. The system is centered around a network of "sentinel providers" who report selected conditions to a state health agency. NIOSH calls this project "Sentinel Events Notification System for Occupational Risks" (SENSOR).

A "sentinel provider" is a physician who either is representative of all practicing physicians in a defined area, or who sees a relatively large proportion of patients with a particular condition. In New Jersey, pulmonologists, allergists, and other physicians are being approached for their cooperation in the SENSOR project. The NJDOH SENSOR project

Table 5. Exposure to occupational allergens: Estimated population at risk in New Jersey.

Industry or Occupation*	Agent or Agents*	Number of Workers**
Printers, Paper Products Manufacturers	Vegetable gums-natural glues	66,945
Lumber and Woodworking Industries	Wood dusts	9,669
Millers and Bakers	Flour, insect, and mite debris	8,788
Veterinarians	Animal danders	1,792
Animal Breeders and Handlers	Animal danders, animal antigens	1,128
Laboratory Workers	Animal danders, animal antigens	2,159
Farm Workers	Animal danders, vegetable dusts, organophosphorus insecticides	5,273
Vegetable Oil Production	Flax seed, castor bean, cotton seed	175
Detergent Industry	Proteases	4,975
Coffee Processing	Green coffee beans	2,525
Beauticians/Cosmetologists	Orris root, paraphenylene diamine, sodium and potassium persulfate	11,767
Pharmaceutical Workers	Penicillin, ampicillin, spiramycin, phenylglycine acid chloride, sulphathiazole, bromelin, amprolium hydrochloride, suphone chloramides, piperazine	28,582
Leatherworkers	Formalin, chromium compounds	3,921
Platinum Refiners	Complex salts of platinum	142
Metal Platers	Salts of nickel, salts of chrome	2,370
Paint Sprayers	Dimethyl ethanolamine, diisocyanates	11,697
Plastics Industry: primary manufacture and use of epoxy resins and polyurethane	Diphenyl methane diisocyanate, hexamethylene diisocyanate, phthalic anhydride, tetrachloro phthalic anhydride, diethylene triamine, diethylene tetramine, piperazine	2,750
Rubber Industry	Ethylene diamine, diisocyanates	175
Total		164,833

*Adapted from: Salvaggio JE, Taylor G, Weill H: Occupational Asthma and Rhinitis, in JA Merchant (ed), *Occupational Respiratory Diseases*. DHHS-NIOSH, U.S. Printing Office, Washington, D.C., 1986.

**Estimates derived from U.S. Department of Commerce, Bureau of the Census. *County Business Patterns 1984: New Jersey*.

encompasses surveillance of silicosis and occupational asthma.

Physician reporting of silicosis to the NJDOH is the logical next step for the NJDOH silicosis surveillance project. The health problem is well-documented; successful workplace intervention

strategies have been developed; and the need for improved diagnostic accuracy has been demonstrated. Followup medical screenings in a limited number of plants have documented that most people with silicosis are not hospitalized for the condition and, thus, are not included in the current surveil-

lance system which is based on hospital reports.

Occupational asthma is a more problematic condition to diagnose. Asthma is a common condition, and occupational asthma can only be distinguished from nonoccupational asthma by occupational asthma's temporal association with chemical exposure. Unless a work history or assessment of exposure is made, the diagnosis easily can be overlooked. Occupational asthma is a potentially significant health problem in New Jersey. There are an estimated 165,000 workers at risk from occupational exposure to allergens (Table 5). Each year, there are approximately 8,500 admissions to New Jersey hospitals for adults with asthma; it is estimated that 5 to 16 percent of these are occupationally related.

SENSOR

Diseases caused by exposure to chemicals or dusts are almost always preventable so long as the causative agents are recognized. The diagnosis of an index case by the astute health practitioner often can be the event that initiates public health prevention and control measures at the source of exposure. As with surveillance of infectious diseases, there needs to be a link between the diagnosing physician and the public health response capabilities at the State Department of Health.

The New Jersey State Department of Health, in cooperation with physicians at the Robert Wood Johnson Medical School, has begun pilot programs for surveillance of occupational asthma and silicosis based on voluntary physician reporting. The New Jersey State Department of Health has identified sentinel physicians in the state who are likely to see patients with those conditions. These physicians are being asked to report patients with occupational asthma or silicosis to the State Department of Health. In turn, the physicians from the medical school will provide diagnostic consultation to the sentinel physicians, and the industrial hygienists from the State Department of Health will determine the sources of exposure to causative agents and recommend procedures for their control.

This surveillance program, called SENSOR ("Sentinel Events Notification System for Occupational Risks"), is being funded in ten states by the Centers for Disease Control in order to demonstrate the effectiveness of active surveillance of certain chemical and dust diseases. Recognition of suspected causative agents by the diagnosing physician linked with public health investigations from the State Department of Health are essential for reducing the burden of these diseases in New Jersey.

For additional information on SENSOR, write Martha Stanbury, NJDOH, CN 360, Trenton, NJ 08625 or call 609/984-1863. For questions about individual patients, call Dr. Howard Kipen at the Robert Wood Johnson Medical School, 201/463-4982.

The New Jersey State Department of Health has been involved in several detailed medical and industrial hygiene evaluations of workers exposed to allergens that have documented the problem at specific worksites.⁹⁻¹²

CASE REPORT

A 28-year-old white male complained of difficulty breathing. His allergist performed various intradermal skin tests which were 2 plus positive for inhalant mix, wool, feathers, ragweed, and Kapock, and 1 plus for tree mix, grass mix, weed mix, and cat and rabbit dander. Sinus films showed mucosal thickening of the ethmoid and maxillary sinuses. His chest x-ray was normal. The allergist prescribed terbutaline and prednisone.

SURVEILLANCE FOR OCCUPATIONAL ASTHMA IN NEW JERSEY

Do you have patients with asthma where you suspect a chemical exposure is the cause? There are approximately 8,500 hospital admissions for adults with asthma in New Jersey. The actual percentage secondary to chemical exposure is unknown, although estimates in the medical literature range from 5 to 16 percent in New Jersey. There are approximately 150,000 individuals working with known allergens. Examples of occupations with exposure to allergens include: laboratory workers (animal danders, insect parts); antibiotic manufacturers (penicillin); detergent manufacturers (*Bacillus subtilis*); precious metal users (platinum); bakers (flour dust); printers (gum arabic, ink ingredients); chemical and plastic manufacturers (MDI, TDI anhydrides).

The New Jersey State Department of Health and the Robert Wood Johnson Medical School have initiated a program to assess the frequency of occupational asthma and to provide support services to individual practitioners. Services offered to practitioners concerned with potential chemical causes of asthma in their patients include telephone consultations with occupational medicine specialists, determination of chemical exposures and levels of exposure, RAST testing for specific chemicals, and reprints of pertinent medical articles. In return, the State Department of Health is asking practitioners to report occupational asthma cases. Even if these services are not needed, the State Department of Health needs to receive case reports in order to identify fellow workers with similar problems who may need medical care or who are at risk of becoming symptomatic.

For additional information on occupational asthma write Martha Stanbury, NJDOH, CN 360, Trenton, NJ 08625 or call 609/984-1863. For questions about individual patients, call Dr. Howard Kipen at the Robert Wood Johnson Medical School, 201/463-4982.

The patient then referred himself to an occupational physician believing work exposures to be the cause of his asthma. The patient had no history of allergy, hay fever, or asthma; he smoked one pack of cigarettes a day.

For three years he worked at a chemical manufacturing plant. After his first year, he was transferred to an area where he emptied bags of himic anhydride, a fire retardant ingredient. Immediately, he began to sneeze; he developed a cold sweat, swelling, redness, and hives around his eyes. He was transferred out, but three months later he experienced swelling of his face and developed hives when transferred back, and in contact with himic anhydride. He was transferred out again, but one year later the bag emptying operation was moved to his area. Six months later, he experienced three separate asthma attacks for which he had seen an allergist.

Upon physical examination, his lungs were clear and pulmonary functions were normal. The patient's white count was 7,300 with 1 percent eosinophils. Radioallergosorbent assay (RAST) for himic anhydride was markedly abnormal. The patient did not return to the plant. His symptoms gradually resolved; one year later he was asymptomatic without medication.

A followup survey at the manufacturing plant found additional symptomatic individuals with positive RAST and skin prick tests. Although engineering controls had been instituted at the plant, additional controls were considered necessary because of the presence of symptomatic individuals.

This case report illustrates the importance of considering chemical exposures, evaluating individuals exposed similarly, and conducting followup investigations to improve controls to reduce exposures.

CONCLUSIONS

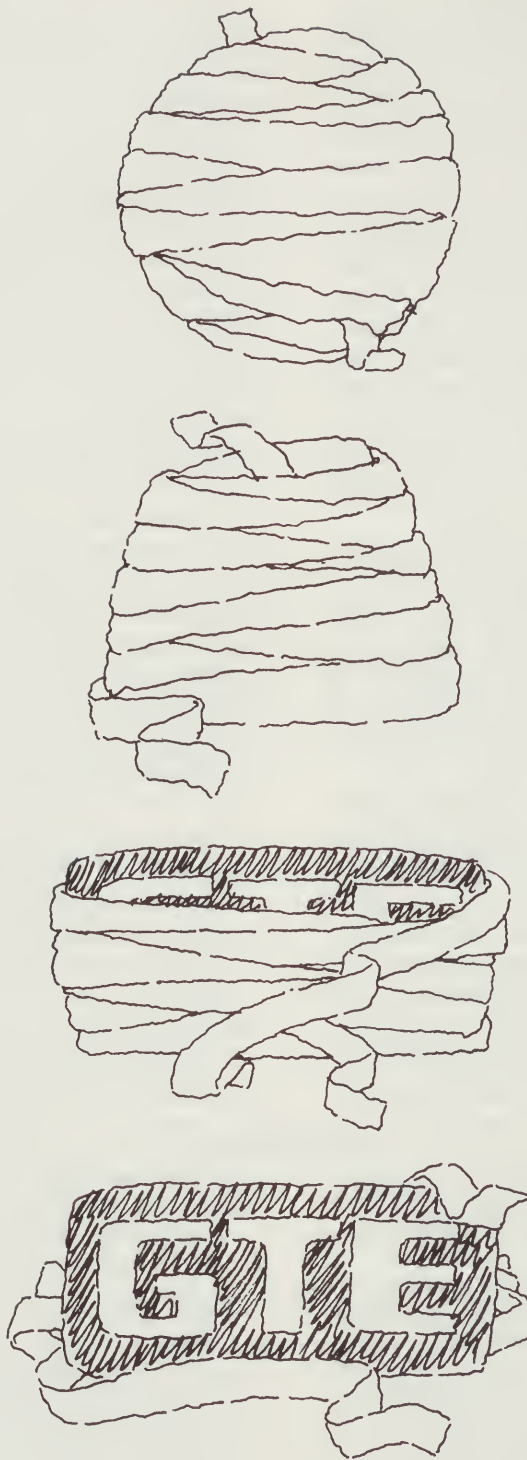
The New Jersey State Department of Health is encouraging physicians to consult with specialists and to report index cases, allowing for the initiation of public health investigations to determine the occurrence of other symptomatic individuals and the types and magnitudes of exposures. Funding from NIOSH for the SENSOR project is promoting this activity. NIOSH has developed standardized diagnostic criteria for silicosis and occupational asthma to be used in the SENSOR program. Physicians at UMDNJ-Robert Wood Johnson Medical School provide diagnostic consultation to targeted sentinel physicians, and industrial hygienists at the Department of Health evaluate cases reported to NJDOH to determine the source of exposure and to recommend proper exposure controls.

Comprehensive chemical and dust disease surveillance programs depend on data from a variety of sources, all of which ultimately rely on accurate diagnoses by physicians. The NJDOH has developed active surveillance of silicosis, exposure to heavy metals, and other chemical and dust-related conditions. The SENSOR project should enhance current surveillance in New Jersey by linking diagnosing physicians with medical consultation and public health investigations at NJDOH.

The experience gained from surveillance for silicosis and occupational asthma eventually will be used to set up a comprehensive system to determine how much chemical and dust-related disease occurs in the state and how best to prevent its occurrence. Special efforts will be necessary to make the system sensitive enough to include conditions caused by exposures found in environmental situations that are less intense than the work setting. ■

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THE POWER IS ON

Reproductive Toxicity

HOWARD M. KIPEN, MD, MPH
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Over the past two decades, medical practitioners have been given increasingly persuasive information that alcoholic beverages, cigarette smoke, illicit drugs, and therapeutic agents may increase the risk of adverse reproductive outcome. There also is growing evidence that environmental and occupational exposures adversely impact on reproduction. Birth defects were the initial focus of this latter concern. The first human teratogen, identified epidemiologically only as recently as the 1940s, was rubella virus. This was followed in the early 1960s by the widely publicized limb reduction defects due to thalidomide use in Europe.¹ An equally shocking but somewhat less well-known example of environmental teratogenicity involved severe central nervous system (CNS) abnormalities due to methyl mercury contamination of the fish supply of Minimata Bay, Japan, in the 1950s and 1960s.²

In 1977, concern suddenly was expanded beyond birth defects to include male reproductive toxicity in an occupational setting when over half of the men working with the nematocide 1,2-dibromo-3-chloropropane (DBCP) were found to be oligospermic and azoospermic, some apparently irreversibly.³ This compound has become one of the handful of workplace agents which the Occupational Safety

Health Administration (OSHA) regulates on the basis of its reproductive toxicity; other agents are lead, ethylene oxide, ionizing radiation, and glycol ethers. However, at least 50 commonly used industrial chemicals in widespread use have been shown to produce reproductive impairment in animals.⁴

In the context of these relatively dramatic and high-profile events, as well as others which have not been scientifically established, e.g. human reproductive toxicity of Agent Orange,^{5,6} this essay will put into perspective the mechanisms and clinical realities of occupational and environmental threats to reproductive health in the 1980s.

The scope of reproductive health problems. There is evidence that certain toxic agents commonly found in an occupational or general environmental setting can adversely affect normal sexual function and the ability to produce healthy offspring. However, what remains problematic is that it often is difficult to define the relationship between exposure to chemical toxins and consequent development of reproductive abnormalities. Two major factors contributing to this dilemma are the complexities of the reproductive process and the biological mechanisms underlying toxicology. Methodologic problems in assessing hazard and risk, such as poor characterization of exposure, extrapolation of animal data to humans, the insensitivity of human epidemiologic techniques, and flaws in many epidemiologic and laboratory studies, also contribute to the difficulty

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of evaluation and prevention of exposure-related reproductive abnormalities.^{7,8}

The spectrum of reproductive health problems includes: dysfunction in male and female reproductive organs; increased incidence of spontaneous abortions and stillbirths; and induction of birth defects (Table 1). Dysfunction in reproductive systems can be organic or functional and includes a wide range of abnormalities: infertility; anovulation; amenorrhea; abnormal gonads, ducts and external genitalia; loss of libido; and male impotence. Infertility, the inability of a couple desiring pregnancy to achieve it after one year of unprotected, untimed intercourse, occurs in approximately 10 to 15 percent of the population. Common estimates are that male-mediated factors and female-mediated factors account for about equal proportions, with 10 to 20 percent not having a recognizable physiologic or anatomic lesion. The underlying cause of many of the lesions, such as azoospermia or poorly motile sperm, frequently is obscure.

Spontaneous abortion is the most frequently occurring adverse reproductive outcome with an approximate rate of 10 to 20 percent of recognized pregnancies. This rate of occurrence actually is an underestimation; if a miscarriage occurs in the first four to six weeks of pregnancy, it easily is misdiagnosed as a menstrual irregularity.

TOXICOLOGIC MECHANISMS

Just as reproduction is complex, the mechanisms controlling a toxic response produced by a chemical are similarly complex and involve absorption, dis-

tribution, metabolism, and excretion.⁹ The mechanisms by which reproductive toxins alter underlying biologic processes can be direct or indirect. The direct effect of the chemical may be secondary to structural similarity to an endogenous compound, such as hyperestrogenism in contraceptive formulation workers,¹⁰ or via more generalized chemical reactivity. Examples of the latter may occur after exposure to alkylating agents such as anti-cancer drugs or sterilizing agents in the hospital setting.^{11,12} Toxicity also may result indirectly from an effect that is mediated via a toxic metabolite.

Finally, the expression of chemical toxicity is determined by an integration of the potential toxic effects of chemicals and various mitigating factors, including body defenses. The main factors which modulate the final effect of environmental reproductive toxins include: pharmacokinetic parameters; capacity of germ cells to repair DNA damaged by mutagens; and limitations imposed on the passage of toxic chemicals by biologic barriers such as the placenta and the blood-testis-barrier.¹³

Reproductive toxicity in the male. In males, it is the rapidly dividing and maturing cells of the seminiferous tubules which seem particularly sensitive to environmental agents, although the hypothalamo-pituitary-gonadal endocrine axis presents several targets for environmental chemicals to exert effects on control of spermatogenesis. The effects of chemical exposure on spermatogenesis include production of sperm which are defective in one or a combination of the following characteristics: number, motility, morphology, or genetic material.¹⁴ Sev-

eral spermatotoxic agents have been identified including 1,2-dibromo 3-chloropropane³ and lead.¹⁵ In addition to adverse effects on the dividing spermatogenic cells, the seminiferous tubular epithelium also may be damaged by agents such as cadmium.^{16, 17} Physical agents such as nonionizing radiation, which may raise tissue temperature, and other heat sources, also may result in reduced sperm production.¹⁸ Ionizing radiation may reduce sperm counts, but is of additional concern because of its mutagenic potential.

Reproductive toxicity in the female. Normal ovarian function is essential for female reproduction. Chemicals may adversely affect the developed ovary through a direct effect on oocytes or follicles, disordered follicular growth, abnormal steroid hormone synthesis or action, disrupted hypothalamic-pituitary-ovarian interactions, inhibited oocyte release, or through altered corpus luteal function. The adverse effects include irregular menstrual cycles, infertility, and genetically damaged oocytes, which when fertilized, may result in nonviable embryos.

Genetic aspects of reproductive toxicity. Many chemicals encountered in the environment or workplace are mutagens, that is they can cause inherited changes in the sequence of DNA. This has profound, although relatively undocumented, implications for human reproductive health since the instructions for the growth and development of an entire organism are contained in the haploid genetic material of the two cells, male and female gametes, which will unite to produce it. Investigations in animals suggest that the changes in sperm morphology may reflect genetic damage in the male germ cell. Although embryonic death or the transmission of genetic aberrations to live born progeny are possibilities, the consequences and likelihood of fertilization by sperm affected by chemical exposure during spermatogenesis (or oocytes affected during oogenesis) are unclear.²¹

As shown in Table 1, there is a high percentage of visually abnormal chromosomes in spontaneously aborted fetuses. Perhaps others have morphologically invisible changes such as point mutations or sister chromatid exchanges (SCEs). Many environmental chemicals, such as alkylating agents like ethylene oxide, are potent inducers of such changes. However, the implications of the actual chromosome aberrations or SCEs on reproductive and other aspects of health are not at all understood. At this point, they may serve more as an indication of exposure than as a predictor of disease or dysfunction.²²

Developmental toxicity. Toxic exposures to the developing conceptus may result in spontaneous abortion, stillbirth, birth defect, neonatal disease, or childhood cancer. The specific outcome of a toxic exposure will be subject to multiple variables,

pertaining to dose, exposure route, additive, synergistic, and antagonistic effects, and unquantifiable aspects of susceptibility. However, a well-documented aspect of developmental toxicity is its time dependence, related in critical and predictable ways to the schedule of early human development.

Significant toxic exposures during the preimplantation period almost always are fatal to the developing organism. Lethal damage technically results in a spontaneous abortion, but may go undetected or be presumed to be a menstrual irregularity. During the embryonic period of development (about weeks three to eight), toxic exposures can produce major structural defects such as neural tube abnormalities or cardiac septal defects. Because of the time specificity of the developmental process, the toxic effect of an agent also is very time specific. Phocomelia due to thalidomide ingestion occurred only when the drug was ingested during weeks five to seven of pregnancy. Outside of this two-week period, thalidomide ingestion caused other effects, or none at all.¹ Specific effects depend on the properties of the agent and on which particular part of the organism is forming at the time of exposure. Unfortunately, the critical first eight weeks of gestation often have passed before pregnancy is diagnosed with certainty, and, thus, before occupational or other environmental exposure can be curtailed effectively.

During the fetal period, lethal outcomes from any given exposure are less common, although spontaneous abortions and stillbirths still can occur. A different spectrum of disorders is considered more characteristic of toxic insult during the fetal period. These include low birth weight, functional neurologic disorders,²³ and transplacental carcinogenic effects such as those attributed to diethylstilbestrol (DES).²⁴

In addition, the postnatal period is not free from hazard. Structural and functional maturation continue after birth, particularly in the nervous, immune, endocrine, reproductive, and drug metabolizing systems. The neonate remains susceptible to workplace and environmental insults, especially through exposure to toxins in breast milk or contaminants brought into the house on clothing.

AGENTS TOXIC TO REPRODUCTION

Table 2 presents information on workplace and environmental agents with the potential to cause adverse reproductive effects in humans. It includes a selection of agents based on multiple criteria including human and animal data. It should be apparent that there is no definitive list of reproductive toxins, because of the limitations of methods for studying human toxicity. For instance, effects observed in one sex and not another may be more

reflective of a paucity of data than of differential toxicity. We have included reproductive hazards with effects only observed in animals, e.g. glycol ethers, because in many instances it may never be possible to develop and analyze a well-designed human experiment. Some of the data substantiating risk in humans are not yet verified, but this information is included based on preliminary reports, e.g. formaldehyde. All applications of lists such as this must be carefully based on a good understanding of the actual circumstances of exposure.²⁵⁻²⁶

ENVIRONMENTAL REPRODUCTIVE TOXICITY

Clinical evaluation of environmental reproductive problems will rely on the knowledge and the facilities of primary care physicians, and often will lead to consultation with experts such as urologists, obstetrician-gynecologists, toxicologists, and genetic counselors. It is important for the primary care physician to have a full understanding of the range of tests, procedures, and options available, and of their limitations, in order to provide guidance to patients.

Males. Physicians frequently are consulted when there is a question of an occupational cause of male infertility. The demonstration of an occupational cause for male infertility is fairly straightforward and requires four steps:²⁷ 1) There must be evidence of a gonadal disorder manifested by an abnormal semen analysis. 2) Nonoccupational causes must be excluded. 3) There must be exposure to a known or suspect agent of testicular dysfunction. Toxicology consultation may be especially valuable since there is no definitive list of spermatotoxins, and one may need to deal with areas of structural similarity of

chemicals or mixtures of compounds. 4) Finally, it is helpful to see improvement of semen parameters after removal from exposure. Because of the complete turnover of sperm in a period of three months, this may be a practical diagnostic aid. Nevertheless, some forms of injury such as oligospermia or azoospermia resulting from damage to the germinal epithelium will not demonstrate such recovery, or it may take substantially longer. Increased follicle-stimulating hormone (FSH) and luteinizing hormone (LH) may indicate primary testicular failure, although usually only in cases of severe dysfunction. In the DBCP exposure referred to in the introduction, high LH levels were present as an indicator of testicular failure. Biomonitoring for toxicant level may guide an expected response to removal from exposure, although this has only been documented to be possible in the case of oligospermia due to lead exposure.²⁸ The primary problem at this point seems to be the lack of reliable biomonitors to indicate or quantify exposure to most toxic agents.

In the male, a conventional sperm assay can be used to evaluate the parameters of number (sperm density), morphology on cytologic examination, and motility compared with various standard values. Inferring cause from abnormal findings is difficult unless a specific agent is known to be present in the environment. There is growing evidence that the abnormal shapes correspond to mutagenic exposures.²¹ Low counts have not yet been established to correlate with genetic damage.

Females. There are no tests of female gametogenesis comparable to a semen analysis. There-

Table 1. Frequency of selected reproductive end points.*

Event	Frequency per 100	Unit
Azoospermia	1	Men
Birth weight <2500 g	7	Live births
Failure to conceive after one year of unprotected intercourse	10-15	Couples
Spontaneous abortion 8 to 28 weeks of gestation	10-20	Pregnancies or women
Chromosomal anomaly among spontaneously aborted conceptions 8 to 28 weeks	30-40	Spontaneous abortions
Stillbirths	2-4	Stillbirths and live births
Birth defects	2-3	Live births
Chromosomal anomalies in live births	0.2	Live births
Severe mental retardation	0.4	Children to age 15 years

*Adapted from Bloom A (ed): *Guidelines for Studies of Human Populations Exposed to Mutagens and Reproductive Hazards*. March of Dimes, New York, NY, 1981.

Table 2. Toxic agents associated with or suspected of adverse reproductive outcomes. *25,26

Exposure or Chemical	Reported Reproductive Effects	Example of Exposure
Anesthetic Gases	Spontaneous abortion Low birth weight Major and minor malformations	Medical Dental Veterinary
Arsenic	Embryolethal and teratogenic in animals	Smelters
Busulfan	Major malformations Decreased sperm count	Medical Pharmaceutical
Cadmium	Low birth weight in animals Malformations in animals Testicular toxicity in animals	Battery Chemical
Carbon Disulfide	Decreased libido Impotence Abnormal sperm morphology and count Spontaneous abortion Decreased fertility in women	Viscose rayon Fumigant
Carbon Monoxide	Fetal neurologic damage in animals Retarded fetal growth	
DBCP (1,2 dibromo-3-chloropropane)	Infertility due to azoospermia, oligospermia	Pesticide
DES (diethylstilbestrol)	Vaginal and cervical adenocarcinoma in female offspring Reproductive tract malformations in male and female offspring	Pharmaceutical
EDB (ethylene dibromide)	Sperm count, motility, and morphology abnormalities in animals	Chemical industry Fumigant
Ethylene Oxide	Spontaneous abortions Birth defects in animals Chromosomal abnormalities	Health care Food sterilization Chemical
Excessive Heat	Lowered sperm counts	
Glycol Ethers	Infertility in animals Teratogenic in animals	Widely used solvents
Hepatitis B Virus	Neonatal hepatitis	Medical Dental
HCB (hexachlorobenzene)	Teratogenicity in animals	Chemical
Ionizing Radiation	Lowered fertility Increased childhood cancer Chromosome aberrations Fetal growth retardation Disrupted gametogenesis	Medical and dental workers Nuclear industry
Kepone	Decreased libido Decreased sperm count, motility, and morphology Decreased fertility in female animals	Chemical, pesticide
Laboratory reagents (benzene, xylene, ethers)	Menstrual disorders Spontaneous abortions Chromosome aberrations	

Exposure or Chemical	Reported Reproductive Effects	Example of Exposure
Lead and Smelter Emissions	Decreased sperm count, and motility Menstrual disorders Spontaneous abortions Prematurity Increased neonatal mortality	Smelting Battery Leaded paint
Mercury (inorganic)	Menstrual disorders	Chemical industry Thermometers and electrical equipment
Methotrexate	Congenital malformations	Pharmaceutical
Methyl mercury	Severe neurological defects	Chemical wastes
PCBs (polychlorinated biphenyls)	Menstrual disorders Stillbirth Pigmentary integumentary and other malformations Low birth weight	Capacitors in telephone/ electrical equipment
Styrene	Menstrual disorders Chromosome aberrations	Plastics workers
TCDD (dioxin)	Teratogenic in animals	Chemical industry
Vinyl Chloride	Chromosome aberrations Miscarriage Stillbirth Sperm abnormalities Birth defects	PVC manufacturing and processing

*Adapted from Kipen HM, Stellman JM: *Reproductive Hazards in the Workplace: A Curriculum in Occupational Health Nursing*. March of Dimes, New York, NY, 1985.

fore, workup of environmental toxicity often is limited to a consideration of the pregnant state. Nevertheless, the history and physical examination remain very important for the evaluation of the individual patient. History of venereal disease, surgery, alcohol, tobacco, medication, and drug use, and contraceptive history are important. The complete reproductive history should include any history of infertility and a record of all known pregnancies and their outcomes, including birth weight.

Pre- and postnatal toxicity. The area of most evident concern with respect to environmental reproductive toxicology in females occurs after conception has occurred, and goes through lactation and the postnatal period. Consider the following three typical situations:

1. The primary consideration in this setting is whether there is specific enough information about both the toxicology of a particular agent, and about the particular individual's exposure to it, to justify a recommendation to avoid further exposure, at least during pregnancy or conception. The usually limited database available for human embryo- and fetotoxicity should be assessed along with the animal

data, the individual's exposure data, and the possibilities and practicalities of effecting change (such as temporary job transfer). This is an exceptionally difficult area because even the absence of exposure cannot assure a good outcome. Furthermore, even in the face of known toxic exposures, untoward outcomes commonly will not be expected in any given pregnancy. Decisions may be even more problematic when the costs of avoiding exposure are socially or financially high, such as when it means finding a new place of employment for the mother, or finding a new water supply.

2. One may need to advise a pregnant woman who already has had a potentially fetotoxic exposure, perhaps because she presents for counselling near the end of the first trimester. There probably are some situations where one may recommend a therapeutic abortion, such as following heavy exposure to known human teratogens such as high-dose organomercurials or ionizing radiation. More commonly, however, this situation will call for reassurance, even in the face of some degree of risk because, with the exception of high-dose situations involving an agent with known dose-response data (such as radi-

ation or medication), one is not commonly in a situation where an adverse outcome has truly become "likely." Again, this is not to say that the risk is not increased. Especially in such a setting, the decision to terminate a pregnancy must obviously involve careful weighing of the best available data by the parents with full knowledge of the uncertainties. Genetic counselling groups are a good source of assistance in quickly marshalling such data, and are experienced with guiding such decisions when needed by patients and physicians.

3. One may need to advise mothers and fathers of young infants about risks from exposures through breastfeeding or bringing toxic agents into the home environment, e.g. dental technicians whose clothes may be contaminated with mercury. Also, many different chemical agents may be concentrated and/or excreted in breast milk, including PCBs, lead, mercury, and others.²⁹

Availability of exposure information is critical to making an informed decision, and frequently is lacking. In addition to the information provided by the patient, every effort should be made to contact an employer or state or local health department for any information, qualitative lists, or quantitative measurements, which will assist in characterizing the type and degree of exposure to toxic agents, past, present, or future. Your patient frequently may be able to assist you in obtaining such information on exposure.

The pregnant worker. In view of increased work of respiration and oxygen demands, the pregnant worker may be more susceptible to asphyxiant agents, such as carbon monoxide. With an increased respiratory rate and tidal volume, the woman may absorb greater amounts of airborne contaminants than when not pregnant. In addition, the pregnant woman has a hyperemic bronchopulmonary system and again she may be more sensitive to particulate matter and allergens such as flour, epoxy, pollen, and sawdust.

There may be other environmental factors which are particularly stressful for the pregnant worker. Extreme heat and humidity can be environmental or caused by occlusive garments. In addition to her own increased metabolic output, the mother's body dissipates fetal body heat, about one degree higher than hers. Consequently, she may be more sensitive to heat and humidity than she was prior to pregnancy.

Medical care of the pregnant worker. The following recommendations have been made by the American College of Obstetrics and Gynecology and NIOSH:³⁰

The normal woman with an uncomplicated pregnancy and a normal fetus in a job that

Table 3. American Medical Association guidelines for continuations of various levels of work during pregnancy.*

Job Function	Weeks of Gestation
Secretarial and light clerical	40
Professional and managerial	40
Sitting with light tasks	
Prolonged	
(more than 4 hours)	40
Intermittent	40
Standing	
Prolonged	
(more than 4 hours)	24
Intermittent	
(more than 30 min/hr)	32
(less than 30 min/hr)	40
Stooping and bending below knee level	
Repetitive	
(more than 10 times/hr)	20
Intermittent	
(between 2 and 10 times/hr)	28
(less than 2 times/hr)	40
Climbing	
Vertical ladders and poles	
(more than 4 times/8 hr shift)	20
(less than 4 times/8 hr shift)	28
Stairs	
(more than 4 times/8 hr shift)	28
(less than 4 times/8 hr shift)	40
Repetitive lifting	
(more than 23 kg)	20
(between 11 and 23 kg)	24
(less than 11 kg)	40
Intermittent Lifting	
(more than 23 kg)	30
(between 11 and 23 kg)	40
(less than 11 kg)	40

*Adapted from Council on Scientific Affairs: Effects of pregnancy on work performance. *JAMA* 251:1995-1997, 1984.

presents no greater potential hazards than those encountered in normal daily life in the community may continue to work without interruption until the onset of labor and may resume working several weeks after an uncomplicated delivery.

Recommendations to deal with biomechanical and exertional factors have been summarized by the AMA and are listed in Table 3.³¹ These are consensus guidelines, and not necessarily based on clinical or other data. They should be viewed as suggestions, rather than firm rules.

CONCLUSIONS

Consideration of the environmental aspects of reproductive toxicity is a field whose prominence is increasing more rapidly than its knowledge base, especially with respect to human data on specific compounds. Characteristic of all aspects of en-

vironmental medicine which deal with questions of causation and prevention, the ability to assess and understand the determinants of exposure are the clinician's primary asset in making reasonable recommendations and determinations, for even the most toxic compound carries less risk than an innocuous one, in the absence of exposure. ■

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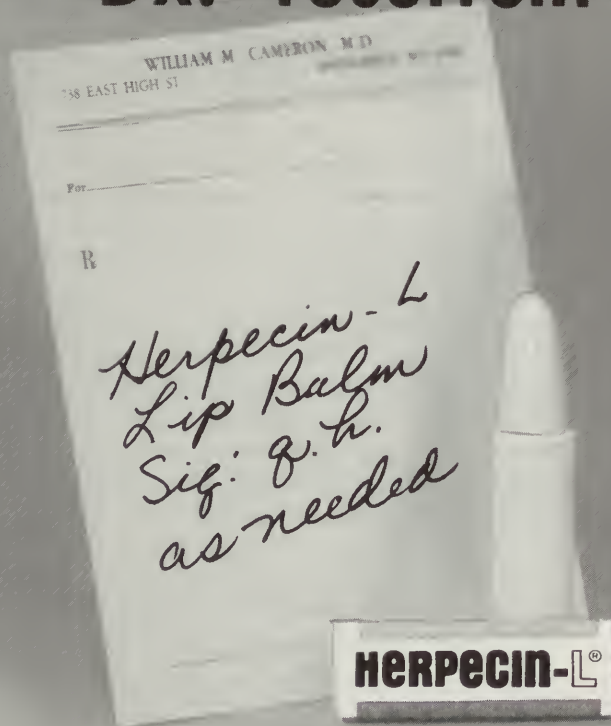
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Clusters of Environmental Disease

DANIEL WARTENBERG, PhD

The study of environmental disease is a relatively new area of scientific investigation. As chemical use in the United States has soared in the post-World War II chemical age, so has the public's awareness of unusual patterns of disease and the science designed to study them. Indeed, clusters of environmental disease have become the scourge of the 1980s, becoming frequent news items in our daily tabloids, overwhelming local health department resources with numerous citizen reports and requests for study, and challenging scientists to devise new and more effective methods of identifying, documenting, and remediating the alleged risks. To differentiate these environmentally induced problems from ones due to other causes, scientists attempt to document anomalous disease rates, identify environmental exposures, and show a plausible link between the two. Unfortunately, many problems often interfere before that task is completed.

In August 1978, New York State Commissioner of Health Robert Whalen warned residents of Love Canal of "a great and imminent peril to the health of the general public residing at or near the site."¹

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Exposure to toxic chemicals was documented, and a health impact was feared. A scandal ensued that resulted in a government buy-out of homes. Subsequent studies reported excess rates of disease, but interpretation of these studies still is controversial.^{2,3} Earlier that year, in Rutherford, residents became concerned about an apparent cluster of 22 cases of childhood leukemia and Hodgkin's disease. The diseases were documented, but a common, causal exposure never was found.^{4,5} In Woburn, Massachusetts, an excessive number of childhood leukemias was noticed by the mother of one of the victims. The problem was confirmed by two studies conducted by government agencies, and academic scientists statistically linked the cluster to a contaminated drinking water supply.⁶ And yet, causation still is debated hotly. In the early 1980s in Santa Clara County, California, an excessive number of birth defects and miscarriages were reported in a region where drinking water had been contaminated by a chemical spill.⁷ Again, although disease excess was documented and putative exposure had occurred, information linking the two was inconclusive.

WHAT IS A CLUSTER?

The scenarios described are clusters. They exist as public health and public relations problems. We try

to understand what each such situation represents, what events might have given rise to this occurrence, and what actions are warranted based on the available information. But, scientifically, what are these things called clusters, why are they so controversial, and why is it so hard to show causation? Quite simply, clusters are aggregations of disease. They may be evidenced by high rates of a common condition, such as spontaneous abortion or miscarriage, a condition which occurs normally in about 15 percent of all pregnancies. More often, clusters are noted as unusually frequent occurrences of rare diseases, such as particular cancers or congenital anomalies.

Clusters are unusual in that the cases of concern are not distributed randomly across all segments of the population, but they are aggregated, or clustered, within one (or more) stratum of the population. For instance, affected residents may live in the same neighborhood, attend the same school, be members of the same family, receive drinking water from the same source, or be workers in the same factory. Problems range from the identification of the population at risk and the statistical evaluation of the case data with respect to the population at risk, to the interpretation of the analysis and communication of the results to the public.

Physicians are in an ideal situation for the early detection of clusters. When they see patients from the same area, social class, and workplace, they have the opportunity to coalesce a large mass of data on disease incidence rates. When anomalous rates are found, they should report these results to public officials and request that the agency undertake further investigation. These results then should be reviewed by the reporting physician as well as by independent experts. Physicians should be receptive to reports of anomalous incidence patterns provided by patients.

Historically, most cluster studies have examined occupational situations. Most often they have focused on the occurrence of some type of cancer.^{8,9} Even so, a number of reports of high rates of environmental disease within particular subpopulations have been noted far back in history. In the 18th century, chimney sweeps were found to have an excess rate of cancer of the scrotum. In the 19th century, John Snow noted that cholera was transmitted through water, and was the causative agent in a cluster of disease in suburban London. But not until the 1960s did the general public begin to appreciate how frequently situations of unusually high disease rates occurred. With that awareness came the suppositions that linked exposures to chemicals at home and in the workplace to adverse health. That was the decade when the evidence for the association between asbestos and lung disease became clear,



when the surgeon general argued that smoking did indeed lead to lung cancer, and when the federal Occupational Safety and Health Administration (OSHA) was created. Environmental awareness and the belief that diseases could occur from exposures to low levels of chemicals over long periods of time became ingrained in the minds of the American public.

With the rising awareness of the ubiquity of cancer-causing agents in our environment, people began paying more attention to disease rates. If they knew of one case of cancer, they began to ask neighbors if they knew of other cases. If there was a particular hazard in a specific neighborhood, they began asking if there were any cases of unusual disease. People had learned of the link between chemicals and disease in some occupational settings and began extrapolating to their own lives. In essence, what had been a surveillance system limited to local physicians was taken over by a concerned public—people wanting to know if there was anything unusual about their neighborhood or their town. Vigilance increased, resulting in increased reporting, and increased reporting created a need for more exact and objective evaluation.

EVALUATING CLUSTERS

To evaluate clusters, investigators have to grapple with a series of problems. Is the alleged cluster a true excess of disease or a statistical artifact? Is the disease related to an environmental exposure or is it due to some other etiology? Are investigators failing to identify many true situations of disease excess? When faced with a report of a disease excess, what should a health official do?

One of the first steps in responding to a report of a cluster is to verify that the observation is unusual statistically. A statistical problem that resulted from the increased vigilance described is the occurrence of false positive (type I errors). That is, the harder you look, the more you find. When vigilance

increased, people began to find many apparent clusters of disease. But only some of what looks unusual statistically, truly is the result of abnormal circumstances.

With disease, one must consider how often we look for unusual rates. If we only look once at one small neighborhood in the entire United States, and we find a rate of cancer much higher than that of the nation overall, that would be reason for concern. The probability of finding such a town in one observation, given the variability of rates, is small. However, with the increased awareness of environmental disease, many residents in many neighborhoods within many communities across the country are looking at disease rates of their families and their neighbors. If we look at each community, and within each community at each neighborhood, occasional excesses are not only expected, but their absence would be unusual. And yet, some of them may be due to unnecessary exposures to toxic materials. We need additional information to be able to verify or discount the problem. In summary, the more often we look for an effect, the more often we will find one, but also the more often the effect will be artifactual, attributable to chance fluctuations.

In addition to increased awareness and reporting, it seems that the clusters of rare diseases, such as leukemia, are identified more often than the clusters of common diseases, such as lung cancer. The reason is we compare rates of incidence of disease in a particular subpopulation to background rates of disease of a "standard" population. In such comparisons, the incidence of a few cases of a rare disease is more unusual statistically than the occurrence of many cases of a common disease. For instance, consider a relatively rare disease, like cancer of the larynx, that accounts for three deaths per 100,000 people in the United States. In a neighborhood of 1,000 people, annually one would not expect to see this as a cause of death at all. If two cases occurred, this would be highly unusual ($P < 0.001$). Based on these data, odds of dying from disease in this community would be 67 times that for the entire United States (an increase of two cases over the expected number of cases). On the other hand, if a disease was the cause of death in 3 out of 1,000 people throughout the country, such as cardiovascular disease, and this occurred in 6 people in this same neighborhood, that would not be unusual (an increase of 3 over expected). The odds of dying from the disease in this community would be two times that for the entire nation, but not statistically significantly different from the entire United States. So, our attention is focused on rare diseases that affect a few people, rather than more common diseases which may affect a large portion

of our community. Two extra cases were more noticeable than three extra cases. In summary, the lower the background rate of incidence of a disease, the fewer cases needed to statistically verify an excess rate, or cluster.

A complementary problem is the detection of false negatives (type II errors). In these situations, data showing a suggestion of clustering are discounted because they are not statistically significant. In part, this may be due to the number of people considered in the subpopulation. As the number of people exposed to toxic material (the population at risk) increases, so the ease of statistically detecting a difference increases (as n increases, the standard error decreases). Consider cardiovascular disease again, with a mortality rate of 0.3 percent (three cases per 1,000 persons) for the United States. For a neighborhood of 100 people, there would have to be a mortality rate of at least 2 percent (two cases per 100 residents) for the neighborhood to be considered statistically unusual. If the neighborhood was defined to contain 1,000 residents, one would need only a mortality rate of at least 0.7 percent (seven cases per 1,000 residents, less than 1 per 100) to find the neighborhood unusual, statistically. The greater the number of people at risk, the smaller the effect that can be detected. Of course, if the study neighborhood is designed to include a large number of people not exposed, or not at risk, this effect will be diluted. In summary, the greater the sample size, the easier it is statistically to detect a specified excess of disease for the entire population, or the smaller change in disease rate that can be detected statistically.

INFERRING CAUSATION

Another problem in the investigation of clusters is inferring causation and the difficulties of relating a particular series of disease events to a particular exposure. Confounding the problem is the variation introduced from person to person and family to family by genetics and environment. Variation of age, socioeconomic status, smoking habits, drinking habits, occupational exposures, and other confounding variables all affect the total risk to which a person is subject. Epidemiologists try to isolate a particular risk factor and then determine if people are more likely to get a particular disease from exposure to that risk factor when the effects of all other risk factors have been removed. Unfortunately, the information on other risk factors is difficult to obtain and the methods of adjustment are complicated.

To verify clusters as regions of high risk rather than as statistical variation, corroborating evidence is necessary. Exposure data is needed. Is there evidence that the "diseased" population had an ex-

posure to a common toxin that is different from the exposure of most other residents? If so, is it possible toxicologically that the exposure caused the disease? Did exposure pre-date detection of the disease, and was there sufficient time to allow for latency, e.g. solid cancer usually takes a minimum of ten years to develop after exposure. Affirmative answers to these questions would suggest a problem. Additionally, disease specificity is checked. In other studies, has the particular disease outcome of concern been linked to a particular toxic agent? Or, have toxicological studies shown a plausible mechanism of action linking the exposure to the disease observed. Does increased exposure in a population correspond to increased rates of disease? Further, we can look at other disease outcomes in the same population. Does the town with a high leukemia rate in children also have a high rate of miscarriages and congenital anomalies? If so, a particular agent may be affecting fetuses and young children.

Finally, in evaluating reports of disease clusters, or their absence, one must consider the source of the report. Residents' reports are likely to be evaluations of crude rates with limited concern for the statistical issues of confounding, bias, and multiple comparisons. My experience with such reports often is that they are reliable within their own context (when people perceive a cluster, there is one, more often than not). But, further analysis to remove confounding variables, or to document exposure, may not identify an ongoing hazard. Lack of adjustment for confounding, inappropriate definition of the population at risk and other technical errors may explain the observation, as well as chance statistical fluctuations. But many clusters also are real and merit prompt attention. When an apparent disease excess is detected, expert analysis should be employed to determine whether there is reason for concern,

further study, or remediation.

Historically, most cases of confirmed clusters have arisen through the investigation of citizen and/or physician-based reports. In New Jersey, a group of physicians (later forming an organization known as Save Our Shores) noted the increased incidence of gastrointestinal problems of a number of their patients. They determined that these individuals had been swimming at the ocean beaches and urged the Health Department to study the problem. One study currently is underway and others are being contemplated. In general, health officials have not developed nor implemented surveillance programs that are as sophisticated as individual case reports reviewed routinely by physicians. Expectations of future computerized systems that routinely census disease registries, DRG, and hospital discharge files abound; until these systems are implemented and tested, we must rely on the astuteness and responsibility of physicians and citizens in the reporting of unusual case findings.

One caveat in seeking expert advice in the investigation of clusters is that public officials have incentives for minimizing the reporting of health risks and failing to identify environmental hazards in a timely fashion. Ozonoff and Boden point out that, for public health officials, consequences for overlooking a true hazard pale in comparison for those erroneously identifying a nonexistent hazard.¹⁰ Commercial, political, media, and public interest groups respond with vigor to officials' reports of clusters, a chain reaction that is difficult to defuse. Failure to identify a hazardous situation, however, does little other than to incite reaction from public interest groups. A tardy apology is the only penalty officials usually have to face. One should seek independent confirmation when concerns about disease clusters are dismissed by public health officials. ■

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Death Rates in New Jersey

MICHAEL GREENBERG, PhD

Thirteen years ago, the National Cancer Institute's first atlas of cancer mortality¹ implied to many New Jersey residents that New Jersey is an unhealthy place in which to live. The legacy of hazardous materials left in abandoned dumps, of air pollution, and of radon supports their fears. Now, there is contrary evidence: for the past two generations, New Jersey's youthful white population has had some of the lowest death rates in the United States,² and New Jersey's cancer rates have decreased compared to the United States as a whole.³

As part of a larger, national time-series study of cancer and seven other major causes of death, mortality trends in middle-age, white New Jersey residents were compared to their counterparts in other states. Results show New Jersey is fast closing the mortality gap—that is, its middle-age population has average, not high, death rates.

DATA AND METHODS

The industrialization of the south and the deindustrialization of the north have transformed the American economy, along with the geography of occupational and environmental risk. Medical services have spread across the country, equalizing access to prevention and treatment. During the study period, 1939-1981, the European-born American population decreased, an important change because this population had higher rates of many diseases, including cancer. Most important, the 40-year period begins before the national highway system, airlines, tele-

vision, national magazines, and other mass media devices helped carry big city behavioral risk factors, such as drug use and smoking, to small cities, towns, and rural areas.

The research analyzed trends of eight major causes of death: heart disease, cancer, cerebrovascular diseases, accidents, suicide, homicide, influenza and pneumonia, and other causes. Finer breakdowns are not feasible because of International Classification of Disease (ICD) reclassifications.

The mortality data are all deaths for these eight categories for the periods 1939-1941, 1949-1951, 1959-1961, 1969-1971, and 1979-1981. The deaths are divided by the number of residents—called the population-at-risk. This population was estimated by extrapolating with a linear line between U.S. Bureau of the Census decennial census counts.^{1,3,4} The 1981 population was estimated by extending the 1970-1980 trend.

Young, middle age, and elderly populations have distinct mortality profiles. Trauma from homicide, suicide, and accidents account for about half of deaths among the under 35 population, compared to less than 3 percent of elderly deaths. Cause of death frequently is difficult to establish among the elderly, especially several decades ago, which is another reason for separate analyses of age groups. Another difficulty is that states, counties, and communities may have high death rates of one age group and low death rates of another, which obfuscates results of studies of all age groups. In fact, New Jersey has had among the lowest rates of youthful deaths and the highest rates of elderly deaths.^{2,3} For these reasons, researchers frequently study the middle-age population—35 to 64—as a barometer of changing mortality.

Requests for reprints can be addressed to Dr. Greenberg, Director of the Environmental Policy Division, Environmental and Occupational Health Center, Rutgers University, Livingston College, New Brunswick 08903.

Table. Comparison of New Jersey and United States white age-adjusted death rates for population ages 35 to 64.

Cause	Sex	Year									
		1939-1941		1949-1951		1959-1961		1969-1971		1979-1981	
		Ratio	Rank	Ratio	Rank	Ratio	Rank	Ratio	Rank	Ratio	Rank
All	M	1.07*	9†	1.07	10	1.03	14	0.94	35	0.95	27
	F	1.14	3	1.15	3	1.12	3	1.02	16	0.99	24
Heart	M	1.22	5	1.14	5	1.13	4	1.04	14	1.04	22
	F	1.38	2	1.30	3	1.28	2	1.15	8	1.02	17
Cancer	M	1.31	2	1.29	1	1.17	3	1.05	12	1.00	26
	F	1.13	7	1.16	2	1.16	1	1.12	2	1.09	7
Cerebrovascular	M	1.03	15	0.98	20	0.88	35	0.89	32	0.94	29
	F	1.15	5	1.08	11	0.98	25	0.90	37	0.91	31
Accident	M	0.99	24	0.67	46	0.62	45	0.61	45	0.63	47
	F	1.07	13	0.76	46	0.65	48	0.68	43	0.75	43
Suicide	M	0.97	23	0.86	39	0.68	46	0.57	47	0.63	48
	F	1.25	6	1.21	9	0.84	15	0.52	48	0.51	47
Homicide	M	0.38	42	0.49	37	0.42	36	0.58	33	0.58	33
	F	0.77	37	0.65	37	0.66	39	0.55	38	0.70	37
Influenza Pneumonia	M	0.92	32	0.96	19	0.98	17	0.94	27	0.99	18
	F	0.59	48	0.92	26	1.09	13	0.96	26	1.01	20
All	M	0.90	36	0.97	27	0.94	32	0.85	43	0.89	40
Other	F	1.03	15	1.05	16	1.04	18	0.93	34	0.91	38

*Ratio of New Jersey and United States rates. †Rank of New Jersey, 1 is highest rate and 48 the lowest.

The nonwhite population is not included because it is too heterogeneous as it includes blacks, Native Americans, Asians, and other subpopulations with markedly different death rates.⁵

To control for age differences between New Jersey and other states, the standard practice of age-adjusting the death rates was used—mathematically controlling for the fact that mortality increases with age. The 1960 population of the United States was used as the population standard. Age-adjusting means that New Jersey's death rates can be compared to rates of other states without age explaining any of the difference.

Two devices are used for displaying the results. Ratios of New Jersey/United States age-adjusted death rates replace actual rates because the ratios make it much easier to spot trends. A ratio of 1.0 means that New Jersey's rate is the same as the nation's; a ratio of 0.80 means that its rate is 20 percent less than the nation's; and a ratio of 1.33 means that New Jersey's rate is one-third higher than the nation's. New Jersey's residents are interested in comparing New Jersey's rates with those of other states. Historical data are available for the 48 contiguous states. New Jersey's rate for each cause of death is ranked 1 to 48; a rank of 1 represents the highest and 48 represents the lowest.

The use of state/national ratios and ranks has the disadvantage of obscuring mortality trends. A death rate could increase from 25 to 50/100,000 and would not be noticed, if the national rate also doubled. Therefore, mortality trends are described briefly.

RESULTS

The death rates for New Jersey's white, middle-age population now are comparable to national rates. New Jersey no longer has among the highest death rates. Numerical rates are presented in the Table, and the Figure compares the ratios in 1939-1941 and 1979-1981.

Heart, Cancer, and Cerebrovascular Diseases. Heart, cancer, and cerebrovascular diseases account for almost three-fourths of the deaths among middle-age New Jersey residents. Death rates from heart diseases have plunged in the 35- to 64-year-old age group. In New Jersey, the male and female rates dropped from over 500/100,000 and 250/100,000, to 316 and 95, respectively. New Jersey's decline was greater than the nation's; the New Jersey/United States ratios have decreased from 1.22 (rank 5) to 1.04 (rank 22) for white males, and from 1.38 (rank 2) to 1.02 (rank 17) for females.

New Jersey's male cancer mortality rate has hovered around 210 for two generations, while the na-

tional rate has increased; and the female rate gradually has decreased from 220 to 178, a greater decrease than the nation's. The result is that the male relative ratio has fallen gradually from 1.31 (rank 2) to 1.00 (rank 26). The female ratio has fallen from 1.13 (rank 7) to 1.09 (rank 7). New Jersey continues to have a relatively high white female cancer mortality rate, albeit the relative ratio has decreased and the age-adjusted rate declined more than 20 percent from 1939 to 1981.

About 4 percent of middle-age deaths are caused by cerebrovascular diseases, e.g. stroke. The death rate has declined to less than one-third of that in 1939-1941. Compared to heart diseases and cancer, cerebrovascular diseases are a major chronic disease that consistently has been characterized by relatively low rates in New Jersey. In 1939-1941, male and female ratios were 1.03 and 1.15 (ranks 15 and 5, respectively); these have declined to 0.94 and 0.91 (ranks 29 and 31, respectively).

Traumatic Causes of Death. Homicide, suicide,

and motor vehicle and other accidents are responsible for 6 percent of deaths in this age group. Homicide rates, especially female, increased during the 40-year study period. Suicide and accident death rates are about half of what they were two generations ago.

New Jersey has had the lowest or among the lowest traumatic death rates of all states for at least a generation. In 1939-1941 and 1949-1951, New Jersey's female suicide rates were higher than the nation's, and the female accident rate was slightly higher in 1939-1941. Now, New Jersey's traumatic death rates are at least 25 percent less than the nation's. This also is true among white youth ages 15 to 24.²

Influenza, Pneumonia, and Other Causes. The death rates for influenza, pneumonia, and other causes in New Jersey and the nation are less than one-third of what they were 40 years ago. Male ratios for the aggregate of all other causes have been low. Female ratios started high, and gradually have de-

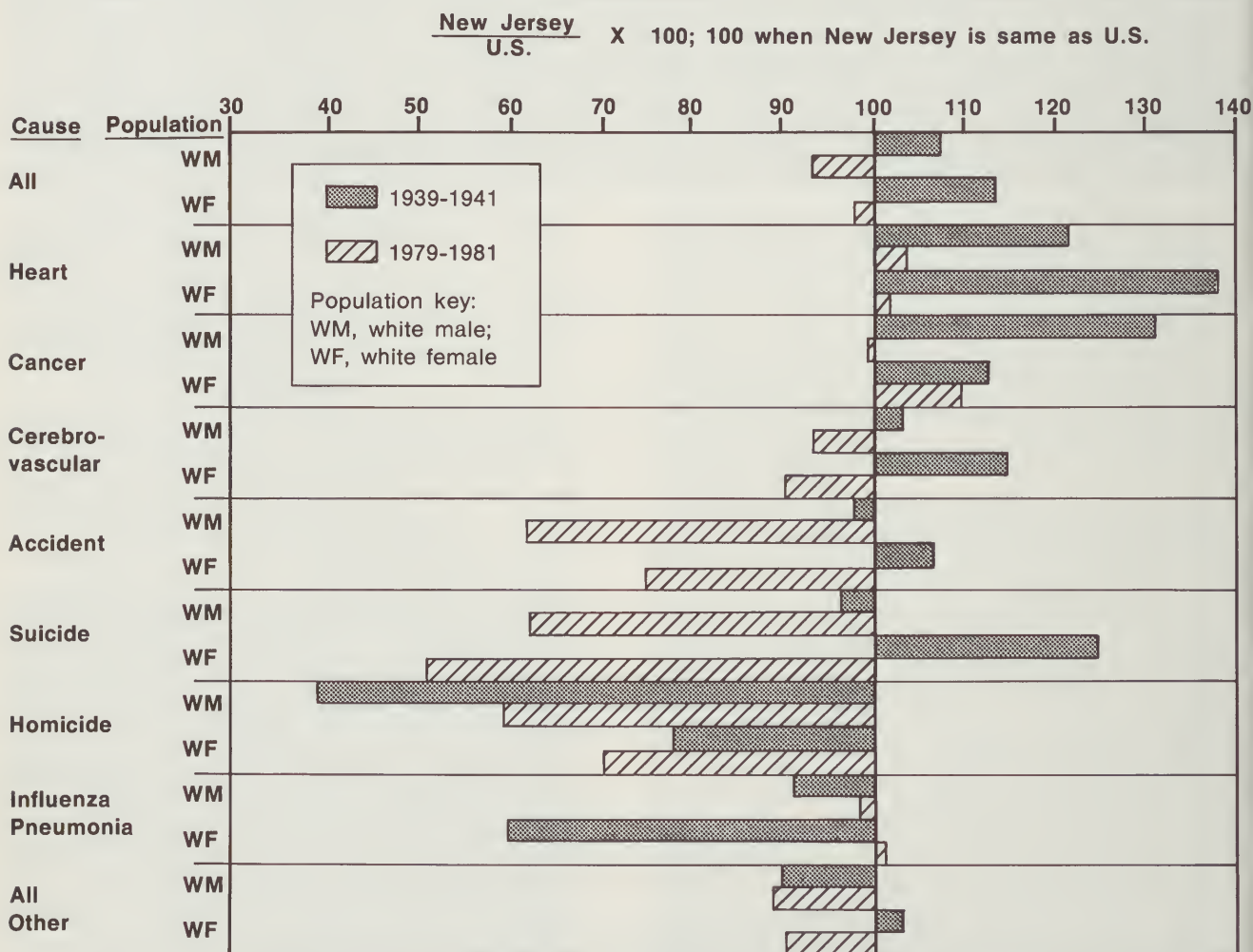


Figure. Comparison of age-adjusted death rates; population 35 to 64 in New Jersey and the United States. 1939-1941 and 1979-1981.

creased to the level of male ratios.

All Causes. New Jersey's female death rate was 15 percent higher than the national rate in 1939-1941 and 1949-1951. New York and Pennsylvania had higher female death rates and eight states had higher male rates. Cancer and heart diseases were the reasons. New Jersey's female death rates were 13 and 38 percent higher than national rates, and male death rates were 31 and 22 percent higher. The relative decrease of these two figures (70 percent of deaths) accounts for New Jersey's decline from relatively high to its current average mortality rates.

Regional Context. Connecticut, Massachusetts, New York, and Rhode Island—New Jersey's northern neighbors—have followed the same path from high to average mortality. The south has replaced the northeast as the high mortality region.⁶ The average total mortality rate of West Virginia, Kentucky, Mississippi, and Arkansas has risen to 13 percent higher than the national rate.

DISCUSSION

Northeastern urban states, like New Jersey, no longer have the highest middle-age population mortality rates in the nation. The urban northeast probably had high heart, cancer, and diabetes rates because the northeastern cities were the starting point in America for many negative habits, i.e. smoking and drug abuse. Now, there is an emphasis on healthier lifestyles. The Centers for Disease Control data show that New Jersey is one of the states leading the nation in stopping smoking and using seat belts.^{7,8} About 35 percent of males aged 35 to 54 in New Jersey and Pennsylvania are reported as current smokers compared to about 55 percent of their counterparts in West Virginia and Kentucky, the states with the two highest mortality trends. Also, occupational and outdoor industrial pollution no longer are concentrated in the north. Finally, it takes two generations for a change from foreign to

native morbidity and mortality patterns; now, northeast mortality profiles resemble national patterns and not European profiles.

There are three explanations for New Jersey's consistently low traumatic death rates:² New Jersey's economy is oriented to services and final stage manufacturing; hence, fewer workers are exposed to the boom and bust stresses of the western extractive economies and the injuries associated with mining, agriculture, and primary manufacturing. Second, New Jersey's families are typically more stable and oriented to religion than their western counterparts—both of which seem to be protective against violence. Third, our monotonous straight roads and short driving trips apparently reduce the probability of fatal road accidents.

The typically healthier lifestyles of the northeast's middle-age population are reinforced by state government policies. New Jersey is one of the most progressive states: George Washington University's study of state cancer protection programs found that New Jersey and its neighbors, Connecticut, Massachusetts, and New York, averaged seven of the nine possible programs; West Virginia, Kentucky, Arkansas, and Mississippi averaged 2.5.⁹ The Conservation Foundation ranked environmental programs in the 50 states;¹⁰ the average rank of the 4 northern states was 7 (very strong); the rank of the four southern states was 30 (weak). In addition, New Jersey has taken a strong posture against drunken driving, speeding, drug abuse, and handgun use.

CONCLUSION

New Jersey is healthier than is commonly believed; yet we should not relax about protecting public health and the environment. If New Jersey is to remain a leader in this field, we must invest in government, industry, research, and educational programs that have helped overturn a legacy of sweatshops, smokestacks, pollution, and poor health. ■

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Risk Communication

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The following patient scenarios are risk communication problems. In each case, the patient has concerns or fears that need to be addressed, has inaccurate or incomplete information about a particular health risk, and has an understanding or perception of the risk that is different from that of an expert opinion.

- A 40 year-old teacher finds out that for the last seven years he has been teaching in a room with asbestos tiles in the ceiling. He says the asbestos tiles have been flaking off and he wants to know about his risk of lung cancer or asbestosis.

- A woman from northern New Jersey mentions that one of her neighbors recently tested her home for radon and the level was below the "safe level" set by the Environmental Protection Agency (EPA). She says she thinks all this stuff about radon is a big hoax, and wants to know if her physician thinks she should have her home tested.

- A 28 year-old woman has had three miscarriages in the last two years. She hears about the superfund toxic dump site a mile from her home and wants to know if her miscarriages could be the result of drinking contaminated well water.

- A radiator repairman says his wife has been complaining that he seems tired and moody. He says he has been having trouble sleeping and has had difficulty concentrating on the job. He also admits to having little interest in sex. An initial blood work-up is negative; however, more indepth testing reveals an elevated blood lead level of 40 mcg/dl. Could the elevated blood level be causing his symptoms? Could it be job-related?

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Patients are becoming increasingly aware of environmental and occupational health hazards. Unfortunately, much of the information available to the public on these hazards is difficult to understand, inconclusive, contradictory, and/or unreliable. In order for individuals to select a protective action, they must be fully informed. Because physicians are perceived to be credible sources of information,¹ they have an important role in this vital process of informing patients about environmental and occupational health risks.

Physicians in New Jersey have the opportunity to be effective risk communicators by addressing the concerns of patients, providing accurate and understandable information about the possible consequences of the health risks, and motivating patients to use available resources and take appropriate action.

RISK ASSESSMENT: EXPERT PERSPECTIVE

Risk assessments utilize clinical studies, epidemiologic research, animal studies, toxicology research, and pharmacokinetic data to answer questions about potential risks, such as: Is a toxic dump site hazardous to the surrounding community? What are the least risky techniques for cleaning up a stream contaminated with PCBs? What is an acceptable minimum level of radon in homes? Is the spraying of pesticides to control gypsy moths a health threat to humans? Is a site contaminated with dioxin hazardous to the surrounding community? If so, what are the best methods of remediation? After a cleanup, what level of PCBs can be left in the soil without public health and the surrounding environment being compromised?

Risk assessment is a step-wise process used to evaluate the probability and magnitude of harm to public health, as well as the environment. While

Table 1. Public perspectives on risk.^{6,7,9}

Situation Perceived as Less Risky

- Voluntary
- Risk(s) known/familiar
- Controlled by self
- Fair
- Not immoral
- Not memorable/not dramatic
- Common hazard/not dreaded
- Consequences easily reduced
- Consequences reversible
- Not fatal
- Effects detectable
- Chronic effects
- Immediate effects
- Spread out over a large area
- Natural
- Individual mitigation possible
- Risk not increasing
- Not global consequences
- No alternatives available

Situation Perceived as More Risky

- Involuntary
- Risk(s) not known
- Controlled by others
- Unfair
- Immoral
- Memorable/dramatic
- Dreaded hazard
- Consequences not easily reduced
- Consequences not reversible
- Fatal
- Effects not detectable
- Acute effects
- Delayed effects
- Concentrated in a specific area
- Artificial
- Individual mitigation impossible
- Risk increasing
- Potential global consequences
- Many possible alternatives

Table 2. Radon risk evaluation chart.*

Radon Levels pCi/L	WL	Estimated Number of Lung Cancer Deaths due to Radon Exposure (out of 1000)	Comparable Exposure Level	Comparable Risk
200	1	440—770	1000 times average outdoor level	More than 60 times nonsmoker risk
				4 pack-a-day smoker
100	0.5	270—630	100 times average indoor level	20,000 chest x-rays per year
40	0.2	120—380		
			100 times average outdoor level	2 pack-a-day smoker
20	0.1	60—210		
				1 pack-a-day smoker
10	0.05	30—120	10 times average indoor level	5 times nonsmoker risk
4	0.02	13—50		
			10 times average outdoor level	200 chest x-rays per year
2	0.01	7—30		
				Nonsmoker risk of dying from lung cancer
1	0.005	3—13	Average indoor level	
0.2	0.001	1—3	Average outdoor level	20 chest x-rays per year

*This chart gives an idea of how exposure to various radon levels over a lifetime compares to the risk of developing lung cancer from smoking and from chest x-rays. The chart also compares these levels to the average indoor and outdoor radon concentrations.

Table 3. Estimated loss of life expectancy due to various causes.[†]

Cause	Days
Cigarette smoking—male	2250
Heart disease	2100
Being 30 percent overweight	1300
Cancer	980
Cigarette smoking—female	800
Stroke	520
Army in Vietnam	400
Dangerous job—accidents	300
Increasing food intake 100 cal/day	210
Motor vehicle accidents	207
Pneumonia—influenza	141
Alcohol (U.S. average)	130
Accidents in home	95
Suicide	95
Diabetes	95
Murdered (homicide)	90
Average job—accidents	74
Drowning	41
Job with radiation exposure	40
Falls	39
Accidents to pedestrians	37
Safest jobs—accidents	30
Fire—burns	27
Poison (solid, liquid)	17
Firearms accidents	11
Medical x-rays	6
Coffee	6
Reactor accidents—UCS*	2
Reactor accidents—Rasmussen*	0.02
Radiation from nuclear industry*	0.02

*These items assume that all U.S. power is nuclear. UCS is Union of Concerned Scientists, the most prominent group of nuclear critics.

†Adapted from Reference 14.

there are several different risk assessment models,^{2,3} they generally include the following steps:

Step 1: Hazard identification involves the identification of the intrinsic hazard of the substance or substances to be evaluated. In addition, health effects related to exposure from the specified hazards are identified for evaluation, e.g. organ toxicity, cancer, reproductive effects, death.

Step 2: Dose response determination identifies the numerical relationship between the hazard and the adverse health effects and environmental impacts associated with exposure to the identified hazard(s).

Step 3: Exposure assessment is an evaluation of the extent of human exposure. This assessment includes route, dose, frequency, duration, and time of exposure. In addition, relevant characteristics of the at-risk population are evaluated, such as the number of people likely to be exposed, proximity of the population to the hazard(s), and potential for increased risk of adverse effects due to factors such as advanced age or pregnancy.

Step 4: Overall risk characterization is the con-

clusion based on the hazard identification, dose-response determination, and exposure assessment steps. This summary usually is a quantitative statement of the likelihood of disease or injury and the magnitude or severity of the health effects resulting from exposure. Information obtained from the risk assessment process can be used to eliminate or control known or suspected health risks, to prevent future potential exposures, or to take other actions to protect the public health.

The risk assessment process is limited by a number of factors including: lack of human and animal toxicology data, limited exposure data, necessary extrapolations from animals to humans, and the use of various mathematical models to extrapolate from high to low dose exposures. Because of the uncertainties involved in the risk assessment process, the overall risk determination often is given as a range.^{2,4} For example, the EPA estimates that between 5,000 and 20,000 lung cancer deaths per year in the United States result from indoor radon levels.⁵ At other times, the conservatism built into the risk assessment process by our prudent regulatory approach, particularly for cancer-causing agents, leads to the provision of a plausible upper bound as a single risk number. When discussing health risks, it is important for risk communicators to recognize the limitations and uncertainties involved in the risk assessment process, and to make these limitations known.

RISK PERCEPTION: PUBLIC PERSPECTIVE

Expert evaluations of the magnitude of a health risk tend to be based primarily on annual mortality or morbidity rates. The public, however, has a more comprehensive view of what a risk entails, focusing less attention on statistics. In their evaluation of riskiness, lay people include a number of factors usually omitted from expert assessments of risk: Are the risks known? Does the risk appear uncontrollable? Is there a potential for global catastrophe? Effective communication about environmental health risks begins with the recognition that while the expert perspective on risk often is different from the public perspective, both points of view are legitimate.^{6,7}

When experts evaluate risk, their responses are related directly to statistical estimates of annual morbidity and mortality rates. Research shows that lay people can estimate annual mortality rates that somewhat are related to the statistical estimates. However, the public's overall evaluation of "riskiness" is determined not only by annual mortality rates or accident probabilities, but also by a variety of other characteristics. As a result, public estimates of risk often are quite different from their own (and

experts) assessment of annual mortality rates.^{6,8} Table 1 lists some of the major characteristics that have been identified as important in the public's definition of risk.^{6,7,9}

People tend to be less concerned about health risks that primarily fall into the "less risky" category and more concerned about health risks that primarily fall into the "more risky" category. For example, household use and disposal of pesticides fall largely into the "less risky category." Household pesticide use is voluntary, familiar, and not dreaded. However, the spraying of a large area with a pesticide or having a toxic dump site in close proximity are of great public concern. Both fall largely into the "more risky category" and are seen as involuntary, controlled by others, and dreaded. Conversely, expert perceptions of risk do not take into account the risk characteristics or factors in Table 1. As a result, there often is misunderstanding and miscommunication between experts and the public.

EFFECTIVE RISK COMMUNICATION

Effective risk communication is a two-way process between the patient and the physician, and involves addressing patient concerns, providing information,^{6,8} and motivating patients to use available resources and take appropriate actions.

Addressing patient concerns. An essential step in risk communication is to recognize that patient feelings are valid. Acknowledgement of the feelings (fear, anger, frustration, and sadness) is an important first step; supporting the patient's concerns when warranted, and providing reassurances otherwise. Statements such as, "You must be very frustrated," or "I understand that you are frightened," can be useful. Find out what the patient cares about and attempt to address those concerns first.^{7,10-12} For example, a patient who wants to know whether or

not to test his home for radon, wants a yes or no answer, not a complex answer explaining the potential risk of lung cancer. It is important to separate the factual issues from the patient's feelings. Until the feelings are addressed, the patient will not be able to pay attention to the facts.

Making complex information understandable.

In risk communication, a major difficulty is presenting information clearly and accurately. Information concerning environmental and occupational health risks often is complex and contains probability statements and uncertainties, which are difficult to explain. There is general agreement that it is not very helpful to warn a patient that he or she has between 10^{-7} and 10^{-8} chance of developing lung cancer from an environmental hazard. Some people

Table 4. Annual fatality rates per 100,000 persons at risk.*

Risk	Rate
Motorcycling	2000
All ages	1000
Aerial acrobatics (planes)	500
Smoking (all causes)	300
Sport parachuting	200
Smoking (cancer)	120
Fire fighting	80
Hang gliding	80
Coal mining	63
Farming	36
Motor vehicles	24
Police work (nonclerical)	22
Boating	5
Rodeo performer	3
Hunting	3
Fires	2.8
1 Diet drink (saccharine)/day	1.0
4 Tbs peanut butter/day (aflatoxin)	0.8
Floods	0.06
Lightning	0.05
Meteorite	0.000006

*From Reference 8, adapted from Reference 15.

Table 5. Risks which increase chance of death by 0.000001 (1 chance in 1 million).*

Risk	Cause of Death
Smoking 1.4 cigarettes	Cancer, heart disease
Drinking 1/2 liter of wine	Cirrhosis of the liver
Spending 1 hour in a coal mine	Black lung disease
Living 2 days in New York or Boston	Air pollution
Travelling 10 miles by bicycle	Accident
Travelling 300 miles by car	Accident
Flying 1000 miles by jet	Accident
Flying 6000 miles by jet	Cancer caused by cosmic radiation
Living 2 months in Denver on vacation from New York	Cancer caused by cosmic radiation
Living 2 months in average stone or brick building	Cancer caused by natural radioactivity (radon)
One chest x-ray taken in a good hospital	Cancer caused by radiation
Living 2 months with a cigarette smoker	Cancer, heart disease
Eating 40 tablespoons of peanut butter	Liver cancer caused by aflatoxin B
Eating 100 charcoal broiled steaks	Cancer from benzopyrene
Risk of accident by living within 5 miles of a nuclear reactor for 50 years	Cancer caused by radiation

*Adapted from Reference 16.

have attempted to explain the meaning of such low probabilities by using analogies such as the likelihood of being hit by lightning and of being struck by a meteorite at the same time. While such explanations may appear to be useful at first, research indicates that explanations of this sort actually can make the problem seem even worse by making it easier to visualize.⁸ Psychological research indicates that information is not very successful in changing people's beliefs when the beliefs are strongly held. Once the individual has developed an opinion, all new information is seen either as supporting that opinion or conflicting with that opinion. Conflicting evidence often is considered to be factually incorrect or unreliable.⁸ In contrast, people lacking strong prior opinions are easily influenced and manipulated by seemingly insignificant factors, such as how the information is presented. For example, an occupational hazard that would double the risk of getting cancer on the job sounds much more serious than an occupational hazard increasing the risk from one in a million to two in a million. In reality, there is not a completely neutral way to present risk information. In fact, the very act of discussing a particular environmental hazard can increase the public's perception of its riskiness.^{4,7,9}

Another problem in communicating about risk is that the public and the media have a tendency to see environmental risk as a dichotomy: Is it risky? Is it safe?⁷ Unfortunately, there is no risk dichotomy. The more appropriate question is, How safe is it?

Recommendations for making complex risk information understandable include:

- Pay attention to how much the patient already knows and relate any new information back to what already is known.
- Use simple, nontechnical language.

- Pictures, graphs, and charts are useful in explaining concepts of risk and probability.

- To explain how dangerous something is, ask the patient to give an example of something they think is extremely dangerous and would never do. Then ask for an example of something they know is a little risky, but they do it all the time anyway. Explain the original danger in relation to what the patient has told you.¹³

- Use risk comparisons to put risks into perspective. (Tables 2 to 5).

PHYSICIAN RESOURCES

Within this special issue, a number of resources at the New Jersey State Department of Environmental Protection and the New Jersey State Department of Health are described. Access to these studies and educational materials can provide critical background information regarding specific health hazards in New Jersey.

Another important resource in this state is the Environmental and Occupational Health Sciences Institute described by Dr. Goldstein in his articles in this issue. One of the six divisions of the Institute, the Public Education and Risk Communication Division, has developed a variety of educational materials that would be suited for patients on such topics as radon, asbestos, reproductive hazards, and children's art supplies. In addition, a wide-range of continuing education courses are offered through this Division that would be of interest to physicians seeking the most recent data regarding environmental and occupational topics. Through *NEW JERSEY MEDICINE*, physicians will continue to be updated regarding future environmental and occupational health initiatives that may impact on the practice of medicine in New Jersey. ■

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Information Sources and Resources

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When asked by patients about exposure to toxic chemicals in the environment or on the job, to whom can a physician turn? The New Jersey State Department of Environmental Protection (NJDEP) and the New Jersey State Department of Health (NJDOH) actively are developing information and expertise doctors can use to evaluate exposure and answer their patients' concerns. In addition, the Environmental and Occupational Health Sciences Institute at Robert Wood Johnson Medical School is helping to develop this information base.

New Jersey health care professionals are on the frontline in their need to understand the prevalence of toxic chemicals in our environment and the effects of these substances on human health. Accurate and timely information on exposure and on health effects are crucial. New Jersey often is cited as the first-ranked state in potential for exposure to hazardous

substances because it has the nation's oldest and most concentrated chemical industry, coupled with the national lead in population density. Moreover, the close proximity of industrial activities to dense population centers has increased the awareness of New Jersey citizens to environmental health issues. These factors have led to the enactment of strict state environmental legislation as well as to the increased concern of citizens about how environmental hazards relate to them on a personal level. Citizen participation in environmental decision making has become a jealously guarded prerogative in New Jersey, and rightly so, as pointed out by Justice David Bazelon of the United States 11th circuit court.¹

Extensive research is needed to provide information to the public and for understanding that will impact regulatory actions as well as personal care provided by health care professionals.

To begin answering questions about human health effects, NJDEP and NJDOH have undertaken a unique cooperative approach in order to promote better coordination between the agencies that, in turn, will lead to improved protection of public

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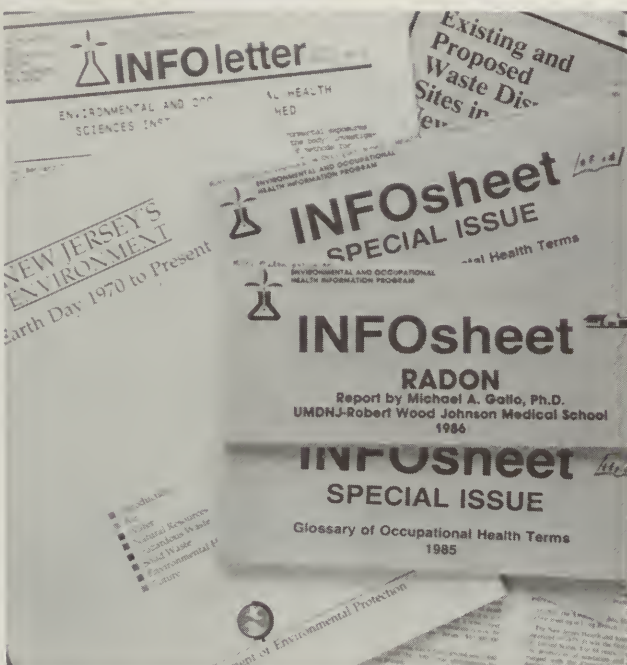
Table. Information phone numbers within DEP and DOH.

Agency	Name	Type of Information	Number
NJDEP	Asbestos Hotline	General information on asbestos, including removal information	(800) 624-2376
NJDEP	Chemical Underground Storage Tanks	General information on regulations regarding underground storage	(800) 722-TANK
NJDEP	Community Right To Know Program	Industrial reporting of chemical use and environmental release	(609) 292-6714
NJDEP	Radon Hotline	General information on radon, radon testing, and lists of New Jersey radon testing firms	(800) 648-0394
NJDEP	Office of Environmental Health Assessment	Site-specific and general environmental health investigations	(609) 984-6072
NJDEP	Information Resource Center	Library including access to environmental health data bases for computer searches	(609) 984-2249
NJDEP	Land Information Program	Environmental status of specific geographic locations upon request	(609) 984-3081
NJDOH	Occupational Health Service	General information on health issues related to occupational exposure; implementation of public employees occupational safety and health provisions	(609) 984-1863
NJDOH	Environmental Health Service	General information on environmental health issues; performance of community environmental health investigations	(609) 633-2043 (609) 633-2595 (609) 292-7101
NJDOH	Asbestos Control Service	General information on residential and commercial asbestos removal; certification of asbestos removal firms	(609) 984-2193
NJDOH	Workplace Right To Know	Enforces workplace provisions in public agencies; development and distribution of fact sheets on over 2,000 chemicals	(609) 984-2202
NJDOH	Smoking	Implements state program on smoking in public and private buildings and businesses	(609) 588-7494
NJDOH	Chronic Illness Prevention Program	General information or referrals to other programs regarding specific chronic illnesses	(609) 588-7503
NJDOH	AIDS	General information and educational material on AIDS prevention	(609) 292-1008
NJDOH	Immunization	General information on immunization programs for children	(609) 588-7512
NJDOH	Communicable Disease Program	General information and investigations on communicable diseases and prevention	(609) 588-7500

health statewide. Part of this approach involves research to develop innovative tools and methods with which to correlate the various information and data bases managed by, or available to, these two agencies. This research will create a better understanding of the impact of human exposure to toxic pollution and also will generate a framework for resolution of potential environmental health problems.

The cooperative approach between NJDOH and NJDEP is part of the overall New Jersey Environmental Health Assessment Program (EHAP), an initiative announced by Governor Kean in 1986.²

The NJDEP component is housed within the Division of Science and Research; the NJDOH component is managed through its Division of Occupational and Environmental Health. Both programs have individual, longstanding histories of investigating the links between toxic environmental pollution and human health effects. The NJDEP Division of Science and Research began tracking the occurrence and fate of toxic substances in New Jersey's air, groundwater, drinking water, and aquatic resources more than a decade ago, and was instrumental in identifying many of the abandoned waste sites now



on the National Priority List under Superfund.^{3,5} The NJDOH Division of Environmental and Occupational Health has investigated environmental and workplace health concerns through monitoring of health indicators, occupational health risk assessments, community health screening, epidemiologic investigations, and health education. Unifying the resources and expertise of the NJDEP and NJDOH programs through the Environmental Health Assessment program promises to be the catalyst New Jersey needs to better protect its environmental resources and the health of its citizens.

SOURCES OF INFORMATION

The common bond necessary for both NJDEP and NJDOH to understand and manage environmental and public health problems is quality scientific monitoring and surveillance data.

Within NJDEP, environmental data, such as ambient air and water monitoring values, are collected for a variety of purposes: enforcement of environmental laws and regulations; compliance with environmental permits; response to emergencies or spills; and performance of research investigations. Examples of NJDEP's major sources of data are summarized in the Table.

Managed by the Division of Science and Research, the NJDEP Information Resource Center serves scientists and policymakers of both departments, as well as outside professionals upon request, through computer search services from a variety of data bases including: DIALOG, MEDLARS (Medical Literature and Retrieval System), and OCLC (Online Computer Library Center).

DIALOG contains over 280 files which can be

searched through a variety of indexes using different search strategies. Although the files span all disciplines, those most often used are found in the categories of the environment, energy, medicine, biosciences, science, and technology. A search can be run simultaneously in a number of files, maximizing the system's capability while minimizing time spent in the system. Search results may be provided as data displays, or in bibliographic formats including abstracts.

The files TOXLINE, MEDLINE, and HSDB (Hazardous Substance Data Bank) are all held in the MEDLARS data base. Of these, the HSDB is used most frequently within NJDEP. HSDB is a data bank that contains toxicological information along with information pertaining to the environment, emergency situations, safety and handling, and regulatory concerns. HSDB searches done by the Information Resource Center are chemical specific and location is made through CAS (Chemical Abstract Service) number of compound name. A chemical reference file is maintained by the Information Resource Center to provide pertinent information, such as results of HSDB searches and safety data sheets.

The Division of Science and Research's Information Research Center is a member of OCLC, a national cooperative of libraries that created and maintains a data base of catalogued records. Records in the OCLC file can be searched through an alphabetic code based on author or title, or by a numerical code that is unique for each work. OCLC is used by the Information Resource Center both for cataloging and for determining interlibrary loan suppliers.

Another data base available through the NJDEP Office of Science and Research is IRIS (Integrated Risk Information System) developed by Dr. Peter Preuss and his colleagues at the United States Environmental Protection Agency (USEPA) Office of Research and Development. IRIS is a computerized catalog of chemical specific EPA risk assessment and risk management information that provides the latest information on EPA health assessments and regulatory decisions for a limited number of chemicals. IRIS files particularly are useful in that they include rationales for regulatory activities.

A unique collection maintained by the Information Resource Center, and often used within the DEP and by members of the public is the Division of Science and Research publication file. Reports, papers, and other publications authored by the staff of OSR are housed separately and indexed by subject and title. In the future, OSR intends to expand this collection to include publications by all divisions of NJDEP, and relevant NJDOH papers. ■

LOCATION MAP

SHERATON MEADOWLANDS HOTEL

Sheraton Plaza Drive—Two Meadowlands Plaza—East Rutherford, NJ 07073

Tel: (201) 896-0500

How to get to the Sheraton Meadowlands

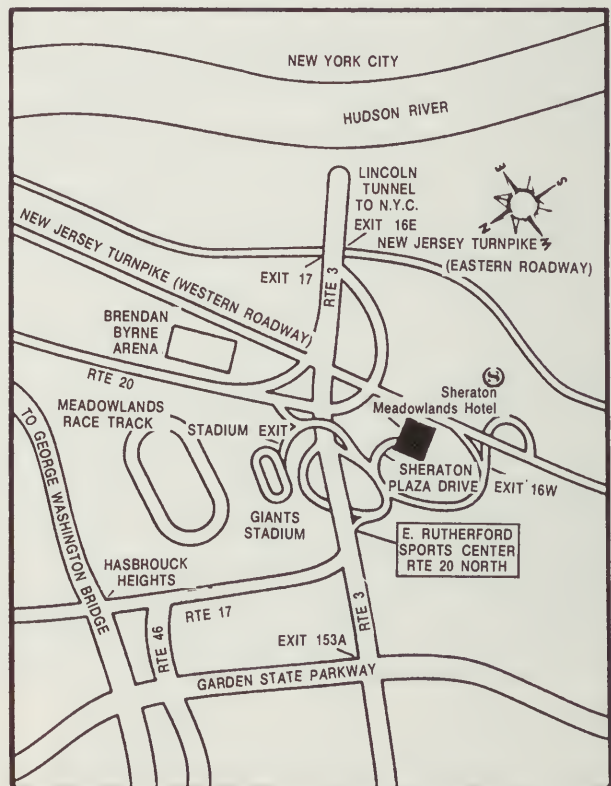
From New York via Lincoln Tunnel: Route 3 W to Sheraton Plaza Drive exit; follow signs to hotel.

From New Jersey Turnpike (N or S): Exit 16 W; follow signs to Route 3 E; stay on service road and follow signs for Sheraton Plaza Drive.

From New York via G. W. Bridge: Take I-95 (N.J. Turnpike) S; exit 16 W and follow as above.

From Garden State Parkway (N or S): Exit 153A to Route 3 E to Route 20 N (Arena) exit; follow signs for Sheraton Plaza Drive.

From Route 17 (N or S): Exit Route 3 E and follow as above.



**HOUSING APPLICATION
HEADQUARTERS HOTEL**

**Sheraton
Meadowlands Hotel**

Sheraton Plaza Drive, Two Meadowlands Plaza-East Rutherford, N.J. 07073
Sheraton Hotels, Inns & Resorts Worldwide
The hospitality people of ITT

223rd ANNUAL MEETING

MEDICAL SOCIETY OF NEW JERSEY

Thursday, April 27, to Sunday, April 30, 1989

_____ Single _____ Double Other _____

Please print or type the following information:

NAME _____

ADDRESS _____

CITY _____

STATE _____ ZIP _____

TELEPHONE NUMBER (_____) _____

ARRIVAL DATE _____ DAY _____

DEPARTURE DATE _____ DAY _____

NAME OF SHARING GUEST _____

CHECK IF OFFICIAL DELEGATE ☐ COUNTY: _____

**\$95/Single
\$95/Double
6% NJ State
Sales Tax**

CHECK-IN: 3 p.m.

CHECK-OUT: 1 p.m.

All reservations will be held until 4 P.M. unless guaranteed with a credit card number or first night's deposit.

Card # _____ Type _____ Exp. Date _____

Sheraton Club International Member Number _____

VISA, MASTERCARD, CARTE BLANCHE, AMERICAN EXPRESS, DINERS CLUB & EN ROUTE
CREDIT CARDS ARE ACCEPTED.

MAIL THIS APPLICATION TO:

Reservations

Sheraton Meadowlands Hotel

Sheraton Plaza Drive, Two Meadowlands Plaza

East Rutherford, NJ 07073

Tel: (201) 896-0500

Reservations must be received by April 5, 1989. Those received after cutoff date will be accepted on a space available basis only.

DOCTORS' NOTEBOOK

Trustees' Minutes; UMDNJ Notes; AMNJ Report; New Members; Physicians Seeking Location in New Jersey

Trustees' Minutes September 18, 1988

A regular meeting of the Board of Trustees was held on Sunday, September 18, 1988, at the Executive Offices in Lawrenceville. Detailed minutes of the meeting are on file with the secretary of your county society. A summary of significant actions follows:

George L. Triebenbacher, M.D. . . . Observed a moment of silence in tribute to the memory of Dr. Triebenbacher and adopted the following memorial resolution:

Whereas, the Almighty has called to His presence, our beloved colleague, George L. Triebenbacher, M.D.; and

Whereas, as a trustee, delegate, and member of the Medical Society of New Jersey, Doctor Triebenbacher served the Medical Society of New Jersey and the people of New Jersey; and

Whereas, he consistently demonstrated the attributes of good citizenship, community service, a dedicated, thoughtful and caring physician, and a loving husband and father; now therefore be it

Resolved, that the Medical Society of New Jersey expresses its profound grief and sorrow at the death of Doctor Triebenbacher and extends its sympathy to his beloved family; and be it further

Resolved, that this resolution be spread upon the minutes of this meeting and a copy presented to his bereaved family in heartfelt sympathy.

Report of the President . . .

1. MSNJ Special Assessment . . .

Voted to have the Executive Committee meet with Mr. Maressa to investigate an alternative means that might be offered through which those members who object to paying the special assessment can satisfy their obligation. Also, voted to continue sending letters to members who have not paid the special assessment.

2. NJ State Nurses Association Representation at Board Meetings . . .

Agreed to extend an invitation to the president and executive director of the New Jersey State Nurses Association to attend monthly board meetings.

Audit Review Committee . . . Will review the report of Ernst & Whinney, MSNJ auditors.

Report of Executive Director . . .

(1) MSNJ Paid Membership . . . Noted there were 7,418 paid members as of August 31, 1988.

(2) AMA 1988 Membership . . . Noted that for the Society there were over 9,000 dues-paying AMA members.

(3) MSNJ Financial Statements . . . Approved the financial statements for the periods ending May, June, July, and August 1988.

(4) License Reform Legislation Update . . . Noted that Mr. Maressa will meet with Judge Herbert J. Stern, representing MSNJ in the matter of the SCI report, to review draft legislation and the legislative format.

(5) Malpractice Reinsurance Association Surcharge . . . Approved the recommendation that Judge Herbert J. Stern be retained as MSNJ's external counsel in the federal court suit.

(6) MSNJ 1989 Membership Directory . . . Noted that the following changes will appear in the printed format for the 1989 *Directory*: retired physicians will be listed by name and address only and only members of MSNJ will be listed by name and specialty in the hospital section.

(7) Boyd versus St. Joseph's Hospital . . . Voted unanimously to reaffirm its previous position, and declined to enter the case amicus.

firm its previous position, and declined to enter the case amicus.

(8) Amicus Request in Appellate Division Appeal . . . Declined to enter this case amicus (an appeal in a malpractice case, in which the issue is specialty designation).

(9) Consultants to the State Board of Medical Examiners . . . Agreed to continue the policy of providing the State Board with a list of physician consultants for peer review.

(10) State Board of Physical Therapy Preproposed New Rule . . . Concurred with Mr. Maressa's suggestion that MSNJ not appear at a hearing on the preproposed new rule on October 6; at such time as a proposed regulation is put forth, MSNJ then would take action and oppose the regulation through a requesting hearing process.

(11) Computerized Severity Index . . . Noted that Robert J. Weierman, M.D., chairman of the Committee on Utilization Review Systems, will inform the Board of developments of the computerized severity index by the Department of Health in answer to physician complaints that the DRG program does not account for the severity of a patient's illness.

UMDNJ Report . . . Received a report from Dr. Stanley S. Bergen, Jr., with comments on the following: the higher education bond issue on the November ballot will provide monies to upgrade the higher education system in the state; resident work hours and supervision in New York State are being monitored; and Dr. Frank J. Malta, chairman of the State Board of Medical Examiners, will restudy the Board ruling that deals with students writing on patient hospital charts.

Pennsylvania Blue Shield . . . Noted that Patrick M. Kiley, director of Medicare, Part B, New Jersey, will direct the New Jersey operation, and he or his designee will attend MSNJ Board meetings. Also, noted that information packets, training sessions, booklets listing codes and terminology, education billing materials, and a toll-free telephone number are being compiled for New Jersey physicians.

AMA Annual Meeting . . . Noted the following from the AMA Annual Meeting:

1. Doctors Karl T. Franzoni and

Joseph A. Riggs, respectively, were appointed chairman and vice-chairman of the AMA delegation.

2. Dr. Robert J. Weierman was elected to the position of member-at-large of the governing council, AMA Hospital Medical Staff Section.

3. Dr. Henry J. Mineur was unsuccessful in his bid for the position on the AMA Council on Constitution and Bylaws.

4. Dr. Palma Formica was elected chairperson of the AMA Council on Long-Range Planning and Development.

5. There is a new internal operating handbook from the AMA delegation.

6. The following resolutions were introduced by New Jersey:

a. Location of Leadership Conferences: Report AAA of the Board of Trustees was adopted stating that an evaluation of the location of the leadership conference will be conducted after a conference held in Chicago in 1989 and conferences held in favorable climates in the east and west in 1990 and 1991.

b. Medicare Reimbursement Categories for Social Admissions and Continued Hospital Stays... Resolution was referred back to the Board of Trustees for report back to the House of Delegates at the 1988 Interim Meeting.

c. Repeal of PRO... Did not adopt this resolution calling for the AMA to actively seek repeal of the federal PRO law.

d. Freedom of Choice for Residency Program Directors... A resolution concerning the selection of candidates for residency programs was not adopted.

e. Medicare Deductibles and Copayments... The following amended resolution was adopted: "Resolved, that the AMA request the federal government to inform the public that physicians accepting Medicare assignment are required to make a reasonable attempt to bill and collect deductible and copayment amounts."

f. Equality of Testing... The resolution requesting the National Board of Medical Examiners and the Educational Commission for Foreign Medical Graduates to administer a single test was not adopted.

g. Graduates of Non-United States Medical Schools... The following substitute resolution was adopted: "Resolved, that the American Medi-

cal Association continue to support the policy that all physicians and medical students be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character.

Committee on Membership Services... Noted that MSNJ has withdrawn endorsement of the Medical Payment Systems, a telecommunications system that electronically files insurance claims.

Committee on Utilization Review Systems... Adopted as amended the following resolution and directed that it be referred to the American Medical Association:

Whereas, various organizations have published reports regarding morbidity and mortality rates of hospitals; and

Whereas, none of the studies were conducted with scientifically accurate or meaningful parameters; and

Whereas, the reports which have been released are misleading and subject to wild speculation; now therefore be it

Resolved, that the Medical Society of New Jersey request the AMA to memorialize the executive and legislative branches of the United States government to refrain

from publishing morbidity and mortality data related to hospitals or physicians unless the information released has resulted from a study that had both meaningful and logically defined parameters and was based upon clinical information that was consistent and verifiable regarding severity of illness issues.

Senior Citizens Task Force...

(1) **State Legislation...** Referred the following recommendation, concerning legislation that would appropriate a grant of \$82,700 to the Central Jersey Health Planning Council, Inc. for the operation of a one-year statewide Medicare toll-free information service, to the Council on Legislation:

That the Medical Society of New Jersey withhold support for A-2597 and S-2458.

(2) Pennsylvania Blue Shield...

Noted that the carrier already has agreed to provide 800 numbers for New Jersey physicians and beneficiaries.

New Business...

(1) **Memo from Abdol H. Islami, M.D., President, Essex County Medical Society...** Referred to the Council on Membership Services and the Committee on Long-Range Planning and Development, a letter from Dr. Islami concerning loss of insurance coverage by New Jersey

CANDIDATES FOR MSNJ OFFICES

If you are interested in becoming an Officer, Trustee, or member of the AMA Delegation, a new opportunity exists for you.

The Nominating Committee will meet several times this year to consider candidates. We will consider members other than those recommended by county medical societies and nominating delegates for any of these offices.

If you wish to be considered, please contact your county medical society or the Medical Society of New Jersey for the necessary forms.

This is a real opportunity for grassroots candidate development and we urge you to use it.

physicians who have had their licenses revoked or suspended.

(2) Vacancies—George L. Triebenbacher, M.D. . . . Noted that the President appointed a screening committee (Drs. Hirsch, Carnes, and Costabile) to solicit nominees to fill vacancies due to the untimely death of Dr. Triebenbacher.

Correspondence . . .

(1) From C. Ross Anthony, Ph.D., associate administrator for program development, Department of Health and Human Services . . . Noted the following response concerning notification of state medical societies six months in advance of anticipated revenue-saving reimbursement changes:

"This is simply not always possible. For example, the Omnibus Budget Reconciliation Act (OBRA) of 1987 included many significant changes in physician reimbursement under Medicare. OBRA was passed on December 21, 1987 and signed into law by the president the next day. Some of the provisions were effective upon enactment, some on January 1, 1988, and although most were effective on April 1, 1988, this was only three months after enactment. Such short time periods make it nearly impossible in some cases to study the legislation and issue instructions to implement the new law in a timely fashion.

As to the request that all physicians be notified three months in advance of any regulatory changes in reimbursement policies, "Medicare law (section 1871 of the Social Security Act) requires that, in general, before issuing a regulation in final form the Secretary of Health and Human Services shall publish the proposed regulation in the *Federal Register* and allow at least 60 days for comment. When the final regulation is published, there usually is a delayed effective date of 30 days. These time periods can be shortened only if authorized by Congress or under very unusual circumstances." Thus, the normal regulations process usually takes at least the three-month period you are requesting.

We sympathize with the difficulty of the physician community in keeping up with the continuing changes in the Medicare program. HCFA and its agents, the Medicare carriers, make every effort to keep physicians abreast of these changes. The complexity and unpredictability of statutory changes do not always allow us to give as much advance notice as we would like.

(2) From James A. Ware, assistant commissioner, New Jersey State Department of Health . . . Noted this response to the suggestion that practicing physicians treating pa-

tients covered under disability, worker's compensation, etc., who receive requests for medical reports, be entitled to reasonable compensation for these additional requests:

The Division of Unemployment and Disability Insurance, and the Division of Workers' Compensation are required by statute to base their benefit determinations on firm medical evidence of disability. These determinations are based upon reports by physicians under whose medical care the individual has been placed. While the statute requires that the claimant submit such medical evidence, it does not have any provisions which relate to the payment of physicians for their services or for their providing reports to the various state agencies.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D., President

The first clinical study of radiation therapy aimed at suppressing the immune system of multiple sclerosis sufferers has shown promising early results at UMDNJ-New Jersey Medical School.

In a controlled study, the research team found the use of total lymphoid irradiation (TLI) will suppress a patient's immune system, allowing for the stabilization of the disease for up to four years.

The study, still in formative stages, is being carried out by a team of neurologists and radiologists led by Dr. Stuart Cook. Dr. Cook, acting dean of our Newark-based school, chairs its Department of Neurosciences.

In a report on the project published in the July supplement of *Neurology*, Dr. Cook and his colleagues reported that there were few serious complications during or after the radiation treatments.

In the study, the investigators treated 27 multiple sclerosis (MS) victims with TLI, while exposing 21 other MS patients to placebo irradiation.

Almost two-thirds of the patients receiving TLI stabilized after therapy and their disease has not worsened during the subsequent four years. In contrast, half the placebo-treated patients worsened within six months of the therapy, 75 percent worsened within 18 months, and 90 percent worsened in 30 months.

Dr. Cook's study showed that those patients with blood-lymphocyte levels below 900 per cubic milli-

meter three months after TLI therapy had a much better prognosis than the controls. According to Dr. Cook, this seems to be a critical blood lymphocyte level. The patients who had placebo irradiation continued to deteriorate, as did those who got TLI, but kept a high lymphocyte count. But the group of TLI patients whose counts went below 900 did not deteriorate significantly during the time they were followed.

Another key factor, Dr. Cook reported, is those patients who received less radiation to the spleen tended to develop lower lymphocyte counts.

Dr. Cook points out that the lymphocyte count may represent a simple, inexpensive barometer for predicting which chronic progressive patients will remain stable or will regress after TLI treatment.

Dr. Cook's study was based on the growing acceptance that MS is an autoimmune disease in which lymphocytes circulating in the blood are thought to attack, directly or through antibodies, the myelin sheaths surrounding the nerve fibers of the brain and spinal cord. Destruction of the myelin blocks transmission of nerve impulses causing the recognized symptoms—loss of coordination, weakness, blurred vision, and others—and the steady decline of the patient over the years.

In the past, TLI therapy has been used to treat patients with lupus erythematosus, rheumatoid arthritis, kidney transplants, and Hodgkin's disease. As the study continues, Dr. Cook and his colleagues will be comparing the results with those of several other immunosuppressive therapies now being tested for MS including cyclophosphamide, azathioprine, cyclosporine, plasma exchange, and lymphocytapheresis.

Congratulations are in order for two members of our faculty:

Benjamin F. Rush, Jr., M.D., professor and chairman of the Department of Surgery at New Jersey Medical School, has been named the first recipient of a special chair in trauma surgery created to advance the study of critical emergency care.

Beckton Dickinson and Company endowed the \$1 million chair at the Newark-based school in honor of Wesley J. Howe, the Franklin Lakes health care company's chairman

and chief executive officer. The endowment was a gift to the Foundation of UMDNJ's \$27.5 million campaign to support key programs at the University.

Raymond A. Adelizzi, D.O., director of the rheumatology division at the School of Osteopathic Medicine, has been elected president of the Lupus Foundation of America, Southern New Jersey Chapter. Dr. Adelizzi, who had been a member of the chapter's board of directors and medical advisory board, also is acting director of the New Jersey Osteoporosis Society. Founded last year, the Stratford-based organization is one of the nation's first self-help groups for osteoporosis sufferers.

AMNJ Report

Benjamin F. Rush, Jr., M.D. President

The Academy's Education Committee under the chairmanship of Dr. Alfred Alessi held a retreat on October 13, 1988. The event was held at the Manor in West Orange; in addition to the Committee, members of the Board of Trustees and Section Officers participated. The agenda included a review of ongoing educational activities as well as a discussion of future initiatives.

The Academy and the Department of Surgery of UMDNJ-New Jersey Medical School sponsored: A General Surgery Review Course on September 30 and October 1, 1988, at the Hilton at Short Hills. The course, under the chairmanship of Dr. George W. Machiedo, provided an extensive review of the topics in general surgery and the surgical specialties, which are likely to be covered on the American Board of Surgery Recertification Examination as well as the Qualifying (written) Examination of the Board.

The Academy of Medicine's Annual Awards Dinner will be held on May 24, 1989, at the Chanticleer in Short Hills. Please reserve the date now and note that nominations for the Edward J. Ill and Citizen's Awards presently are being accepted.

The 13th Annual New Jersey Orthopaedic Symposium cosponsored by the New Jersey Orthopaedic Society was held on October 28 and 29, 1988, at the Hyatt Regency in New Brunswick, with Dr. Napoleon Val-

dez as program chairman, and Dr. Steven Berkowitz, as co-chair. The all-day program featured guest speakers: Dr. Sherman Coleman, University of Utah; Dr. Edward Craig, University of Minnesota; Dr. James Fox, Southern California Orthopaedic Institute; Dr. John Fulkerson, University of Connecticut; Dr. Robert Protzman, Orthopaedic Surgery Department of the John Peter Smith Hospital in Fort Worth, Texas; and Dr. Franklin Sim, Mayo Clinic. The symposium was designed to provide an opportunity for orthopaedists in the tristate area to hear timely topics of current interest presented by national leaders in various fields.

Dr. Robert Eisinger again will chair this year's *Internal Medicine Review Course*, scheduled to begin in mid-January and run for 19 Wednesdays from 4:00 P.M.-7:00 P.M. The course will be held at the Robert Wood Johnson University Hospital in New Brunswick. The course is cosponsored with UMDNJ-Robert Wood Johnson Medical School as well as Robert Wood Johnson University Hospital.

The course is designed to provide a comprehensive review of contemporary concepts in internal medicine. It is designed for practicing internists and family practitioners. The review also will be useful for residents in preparation for the ABIM examination. Syllabus material will be distributed during the course which, when compiled, will provide an extremely useful reference.

New Members

The Medical Society of New Jersey would like to welcome the following new members:

Atlantic County

Lawrence J. Anastasi, D.O., Margate City
John T. Bannon, M.D., Somers Point
Reva Dubin, M.D., Ventnor
Paul M. Kirschenfeld, M.D., Linwood
John A. Saia, D.O., Hammonton
Scott W. Strenger, M.D., Margate

Bergen County

Grace L. Adofa, M.D., Englewood
Gregory V. Babigian, M.D., Paramus
Herve M. Byron, M.D., Englewood
Zinaida Z. Chachashvili, M.D., Fair Lawn
John G. DeGhetto, Jr., D.O., Paramus
Serge Dumay, M.D., Bergenfield
Michael R. Gentile, M.D., Teaneck
Russell F. Guba, Jr., M.D., Cresskill
Jeffrey R. Lefkowitz, M.D., Fair Lawn
Kildeen E. Moore, M.D., Ramsey

Anthony P. Nicosia, M.D., Cliffside Park
Jonathan Smith, M.D., Ridgewood
Sunilkumar J. Vaidya, M.D., Lodi

Burlington County

Lewis M. Judy, M.D., Vincentown
Jesus Sosa, M.D., Willingboro

Camden County

Robert J. Biester, M.D., Collingswood
Donald L. Brody, M.D., Voorhees
Peter D. Buckman, M.D., Haddonfield
Anita P. Bulei, M.D., Upper Darby, PA
Linda R. DeGaeta, M.D., Camden
Norman J. Doherty, M.D., Voorhees
Marietta L. Galvez, M.D., Voorhees
Alan D. Kramer, M.D., Voorhees
Richard C. Laucks, M.D., Haddon Heights
Wendy Martinez, M.D., Cherry Hill
Kathleen M. Meehan, M.D., Voorhees
Cyrus Mohazzebi, M.D., Cherry Hill
Robin L. Perry, M.D., Blackwood
George J. Petruncio, M.D., Sewell
Barbara A. Rabb, M.D., Cherry Hill
Ping-An Tjoa, M.D., Cherry Hill

Cumberland County

Bernard E. Benson, M.D., Millville

Essex County

Alan W. Dunton, M.D., Newark
Robert J. Fieldman, M.D., West Orange
Thomas C. Hall, M.D., Newark
David J. Lange, M.D., West Orange
Stuart P. Leitner, M.D., Livingston
Patrick D. Manze, M.D., Chatham
Raphael S. Paisner, M.D., Verona
Ruby J. Sampson, M.D., Orange
Surekha U. Shah, M.D., Maplewood
Najam Wasty, M.D., Newark
Mathias Zemel, M.D., Newark

Hudson County

Gary P. Cardiello, M.D., Jersey City
Teofilo A. Dauhajre, M.D., Union City
John T. Dedousis, Jr., M.D., Bayonne
Adolfo C. Fernandez-Obregon, M.D., Hoboken
Karen L. Omilian, D.O., Union City
William F. Oser, Jr., M.D., Jersey City
Edwin P. Schulhafer, M.D., Hoboken
Gayle Shulman, M.D., Bayonne

Mercer County

Michael Y. Baaklini, M.D., Cranbury
Adolfo R. DeSandre, M.D., Lawrenceville
Robert R. Ford, M.D., Princeton
Steven R. Gecha, M.D., Princeton
Rene S. Gomez, M.D., Lawrenceville
Douglas R. Hough, M.D., Princeton
Daniel K. Jass, M.D., Pennington
Michael N. Jolley, M.D., Princeton
C. Alexander Moskwa, Jr., M.D., Princeton
Gregg S. Pressman, M.D., Mercerville
Ernest T. Roman, M.D., Mercerville
Moshe M. Rothkopf, M.D., Lakewood
David J. Sand, M.D., Lawrenceville
Michael A. Schiavone, M.D., Pennington
Alicia C. Tayao-Tesoro, M.D., Trenton
Arnold S. Witte, M.D., Trenton

Middlesex County

Charles H. Brown, M.D., Perth Amboy
Alieta R. Eck, M.D., Piscataway
David S. Goldstein, M.D., Iselin
Diane J. Kmec, M.D., Somerset
Joseph J. Perosi, M.D., Milltown
Dorothy M. Quail, M.D., North Brunswick

Audrey M. Weissman, M.D.,
North Brunswick
Donald W. Zarfes, M.D., Edison

Monmouth County

Jeffrey M. Beal, M.D., Ocean Grove
Steven G. Crawford, M.D., Neptune
Thomas C. Fiest, D.O., Ocean
Nasir H. Gardezi, M.D., Long Branch
Dominick A. Grosso, D.O.,
Atlantic Highlands
Marcus Hanfling, D.O., Red Bank
Margaret A. Lambert-Wooley, M.D.,
Long Branch
Nilesh J. Patel, M.D., West Long Branch
John Pelligra, M.D., Haledon
Robert J. Schuman, M.D., Valhalla, NY
Richard J. Scott, M.D., Red Bank
Stefano R. Tarantolo, M.D., South Amboy
Charles Valases, M.D., Long Branch
Louis J. Zinterhofer, M.D., Long Branch

Morris County

Irvin M. Bonder, M.D., Denville
Mitchell C. Chasin, M.D., Summit
Mary V. Daly, M.D., Morristown
Michael D. Dick, M.D., Morristown
Robert W. Dickson, M.D., Bridgeton
Pahirathi E. Haran, M.D., Morris Plains
Jory G. Magidson, M.D., Morristown
Shyamala Parimi, M.D., Dover
Patricia M. Renz, M.D., Rockaway
Richard S. Rosenberg, M.D., Morristown
Noel R. Sorvino, M.D., Mendham

Ocean County

Kevin F. Clancy, M.D., Toms River
James F. Clyde, M.D., Toms River
Cathleen O. Doane-Wilson, M.D.,
Fort Monmouth
Joseph E. Domanski, M.D.,
Point Pleasant
Rudolph E. Gronsky, D.O., Brick
Francis J. Kelly, M.D., Toms River
Robert A. Monaco, M.D., Manasquan
Sean C. Rowland, M.D., Howell
Joseph C. Tauro, M.D., Toms River
Steven M. Wanderman, M.D.,
Massapequa, NY
Barry L. Zimmerman, D.O., Lakewood

Passaic County

Victor D. Antonacci, M.D., Fort Lee
Gurmit S. Chilana, M.D., Paterson
Eileen M. Clifford, M.D., Fair Lawn
Lisa Ferraro, M.D., Hillsdale
Richard E. Krieger, M.D., Wayne
Byong K. Park, M.D., Lyndhurst
Robert D. Shlien, M.D., Wayne
Binod P. Sinha, M.D., Edison
Pamela J. Tropper, M.D., Paterson

Somerset County

Eric R. Braverman, M.D., Skillman

Harlan E. Hiramoto, M.D., Bridgewater
Douglas R. Krohn, M.D., Somerville

Union County

Barry M. Cohen, M.D., San Diego, CA
Brenda E. Holcomb-Simone, D.O.,
Roselle Park
Scott M. McGinley, M.D., Summit
Timothy S. O'Donnell, D.O., Clark
Elizabeth A. Panzner, M.D., East Hanover
Steven R. Parmett, M.D., Springfield
Elizabeth C. Quinn, M.D., Plainfield
Robert J. Roland, D.O., Union
John A. Watson, M.D., Summit

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY—Grant H. Greeley, M.D., 6305 Snow Heights Ct., El Paso, TX 79912. SUNY Downstate 1979. Also, internal medicine. Board certified. Also, board certified (IM). Partnership or multi-specialty group within commuting distance of New York City. Available May 1989.

ANESTHESIOLOGY—Michael Silverberg, M.D., 2020 Walnut St., Apt. 29K, Philadelphia, PA 19103. Yale 1983. Board eligible. Available. July 1989.

FAMILY PRACTICE—Neil S. Skolnik, M.D., 1114 Spruce St., Philadelphia, PA 19107. Emory 1984. Board certified. Group or partnership. Available.

GASTROENTEROLOGY—Howard P. Fritz, M.D., 14 Baldwin Ct., Newington, CT 06111. St. Louis 1984. Also, internal medicine. Board eligible. Board certified (IM). Available July 1989.

K. Suresh Reddy, M.D., 280 Henderson St., #16J, Jersey City, NJ 07302. Kakatiya Medical College (India). Also, internal medicine. Board eligible. Board certified (IM). Solo or group. Available June 1989.

INTERNAL MEDICINE—Diane Barton, M.D., Village of Stoney Run, Apt. 571,

Maple Shade, NJ 08052. Temple 1984. Board eligible. Group, partnership, solo. Available July 1989.

Howard P. Fritz, M.D., 14 Baldwin Ct., Newington, CT 06111. St. Louis 1984. Also, gastroenterology. Board certified. Available July 1989.

Grant H. Greeley, M.D., 6305 Snow Heights Ct., El Paso, TX 79912. SUNY Downstate 1979. Also, allergy. Board certified. Also, board certified (ALLERGY). Partnership or multispecialty group within commuting distance of New York City. Available May 1989.

K. Suresh Reddy, M.D., 280 Henderson St., #16J, Jersey City, NJ 07302. Kakatiya Medical College (India). Also, gastroenterology. Board certified. Solo or group. Available June 1989.

NEURORADIOLOGY—Jerome G. Wiot, M.D., 803 East 6th St., #401, Newport, KY 41071. Cincinnati 1982. Board certified. Group or academic. Available July 1989.

NEUROSURGERY—Hae Dong Jho, M.D., Ph.D., 8327 Elaine Dr., Pittsburgh, PA 15237. Chonnam University 1971. Board eligible. Group, partnership, solo. Available June 1989.

OPHTHALMOLOGY—William Brian Neusidl, M.D., 200 Riverfront Pk., Apt. 13C, Detroit, MI 48226. Temple 1984. Board eligible. Available July 1989.

ORTHOPEDIC SURGERY—Paul Bizzigotti, M.D., 230 E. 12 St., #7A, New York, NY 10003. NYU 1981. Board eligible. Group or partnership. Available. Joseph M. Grant, M.D., Naval Hospital, Box 8, FPO, San Francisco, CA. UMDNJ 1980. Board eligible. Group or partnership. Available July 1989.

PEDIATRICS—Elizabeth Lubas, M.D., 508 Third St., Lyndhurst, NJ 07071. Boston University 1986. Board eligible. Group or partnership. Available.

RADIOLOGY—Joseph M. Ullman, M.D., 148 Chestnut Crossing Dr., Apt. 1, Newark, DE 19713. George Washington 1984. Board eligible. Group, partnership, community hospital, outpatient imaging center. Available July 1989.

SURGERY—M. Amawi, M.D., 1904 Barham Blvd., Dodge City, KS 67801. Board certified. Group or partnership. Available.

**1989 MSNJ
ANNUAL MEETING
April 27-April 30, 1989
Sheraton Meadowlands Hotel
East Rutherford**



Hahnemann University

DEPARTMENT OF MEDICINE

GRAND ROUNDS

Presented by:

William S. Frankl, M.D.

Professor of Medicine
Chairman, Dept. of Medicine

Allan B. Schwartz, M.D.

Professor of Medicine, Deputy Chairman
Graduate Medical Education

November 2, 1988	Vasodilators in Medicine
November 9, 1988	Pharmacokinetics of Cardioactive Drugs
November 16, 1988	Diabetic Nephropathy and Hypertension
November 23, 1988	Acute Leukemia
November 30, 1988	Management of Hyperlipidemia
December 7, 1988	New Concepts in Ischemic Heart Disease
December 14, 1988	Pituitary Tumors
December 21, 1988	CPC

ALL GRAND ROUNDS BEGIN AT 8:30 A.M.

Classroom C (Alumni Hall), New College Bldg.
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For further information: Office of Continuing Education, (215) 448-8263

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Hahnemann University

DEPARTMENT OF MEDICINE

MEDICAL SEMINAR SERIES

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William S. Frankl, M.D.

Professor of Medicine
Chairman, Dept. of Medicine

Allan B. Schwartz, M.D.

Professor of Medicine, Deputy Chairman
Graduate Medical Education

NOVEMBER 2, 1988

TREATMENT OF HYPERTENSION

1:00 to 4:00 P.M.

Course Director: Charles Swartz, M.D.

Guest Faculty: Norman Kaplan, M.D.
Martin B. Leon, M.D. Barry F. Uretsky, M.D.

NOVEMBER 30, 1988

MANAGEMENT OF HYPERLIPIDEMIA

1:00 to 4:00 P.M.

Course Director: Stuart Snyder, M.D.

Guest Faculty: Basil M. Rifkind, M.D.

DECEMBER 7, 1988

VALVULAR HEART DISEASE

1:00 to 4:00 P.M.

Course Director: William S. Frankl, M.D.

Guest Faculty: James F. Spann, M.D.

Classroom C (Alumni Hall), New College Bldg.
15th & Vine Streets, Philadelphia, Pennsylvania

For further information: Office of Continuing Education,
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CLINICAL UPDATE PULMONARY MEDICINE

COURSE DESCRIPTION:

December 7, 1988

The 5th Annual Clinical Update is designed to provide family practitioners, general internists, pulmonologists and other interested physicians with an updated review of pulmonary disorders which are commonly encountered in clinical practice as well as certain disorders which are of current topical interest. The program has been carefully selected to ensure a good blend of established and new methods and approaches to pulmonary diseases.

The morning session will provide participants with systematic approaches to chest x-ray interpretation, pleural effusion, atypical pneumonias (*Legionella*, *Mycoplasma*, *Chlamydia*, viral, fungal) and pulmonary disorders produced by cardiovascular disease.

The afternoon session will present current concepts in the diagnosis and management of idiopathic pulmonary fibrosis and lung cancer. A special lecture will focus on the current status of lung transplantation for end-stage pulmonary disease. This session will conclude with a discussion of the pulmonary assessment and management of the surgical patient with lung disease.

Throughout the day, emphasis will be placed on risk factors, natural history, early detection, prognosis, newer diagnostic techniques and new methods of therapy.

A.M.	MORNING SESSION	P.M.	AFTERNOON SESSION
8:00	Registration	12:30	Luncheon
8:50	Welcome— <i>Vladir Maranhao, M.D.</i>	1:30	Clara Falk Franks Lecture—Clinical Decisions in Idiopathic Pulmonary Fibrosis <i>J.A. Peter Paré, M.D.</i>
9:00	A Practical Guide to Chest X-Ray Interpretation <i>Wallace T. Miller, M.D.</i>	2:20	Lung Transplantation for End-Stage Pulmonary Disease <i>Joel D. Cooper, M.D.</i>
9:50	Differential Diagnosis of Pleural Effusions <i>Steven A. Sahn, M.D.</i>	3:10	Coffee Break
10:40	Coffee Break	3:25	Lung Cancer in 1988—Staging and Expectations of Surgery <i>Joel D. Cooper, M.D.</i>
10:55	Pulmonary Disorders Produced by Cardiac Disease <i>David M.F. Murphy, M.D.</i>	4:15	Reducing the Risk of Postoperative Pulmonary Complications <i>Mervyn Feierstein, M.D.</i>
11:45	The Spectrum of Atypical Pneumonias <i>Steven A. Sahn, M.D.</i>	5:00	Adjourn

Tuition: All participants, fee includes luncheon and refreshments—\$80.00.

A check in the amount of \$80.00 payable to Deborah Heart and Lung Center should accompany this application. Mail to Pulmonary Department, Deborah Heart and Lung Center, Browns Mills, N.J. 08015.

Due to limited seating capacity, early registration is strongly advised.

For Program Information please call: Mrs. Diane Colby (609) 893-6611.

Registration deadline—Wednesday, November 23, 1988.

Accreditation: Deborah Heart and Lung Center designates that this continuing education offering meets the criteria for 6.5 credit hours in category 1 of the Physician's Recognition Award of the American Medical Association.

This program has been reviewed and is acceptable for 6.5 prescribed hours by the American Academy of Family Physicians.

CME CALENDAR

The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization (indicated in italics) for further information.

ALLERGY

December

- 9- **Allergy and Nutrition**
11 7:30 A.M.-4:30 P.M.—The Pointe at Tapatio Cliffs, Phoenix, Arizona (*Holy Name Hospital*)

ANESTHESIOLOGY

January

- 17 **Postanesthetic Apnea in the Former Premature Infant**
6-10 P.M.—Ramada Inn, Clark (*NJSSA*)

CARDIOLOGY

December

- 1 **Valvuloplasty**
11 A.M.—St. Joseph's Hospital and Medical Center, Paterson (*St. Joseph's Hospital and Medical Center*)
- 8 **How To Decide on Therapy for Acute Myocardial Infarction**
12 noon-1:30 P.M.—Somerset Medical Center, Somerville (*AMNJ*)
- 20 **Advances in the Treatment of Arrhythmias**
9-10 A.M.—Holy Name Hospital, Teaneck (*Holy Name Hospital*)

January

- 13 **Angioplasty**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton (*Bridgeton Hospital*)

- 18 **Cardiology**
10:30-11:30 A.M.—Christ Hospital, Jersey City (*Christ Hospital*)
- 27 **Thromboembolism and Thrombolytic Therapy**
7:30-8:30 A.M.—Atlantic City Medical Center, Atlantic City (*AMNJ*)

DERMATOLOGY

January

- 10 **Dermatological Society of New Jersey**
7-10 P.M.—Shering-Plough Corporation, Kenilworth (*Dermatological Society of New Jersey*)
- 12 **Principles of Dermatologic Therapy**
1:30-2:30 P.M.—Vineland Developmental Center, Vineland (*AMNJ*)

INFECTIOUS DISEASES

December

- 6 **Clinical Management of HIV Infection**
8-9 A.M.—Underwood Memorial Hospital, Woodbury (*AMNJ and NJSDOH*)
- 7 **Clinical Management of HIV Infection**
11:30 A.M.-12:30 P.M.—Hamilton Hospital, Trenton (*AMNJ and NJSDOH*)
- 7 **Counseling and Testing for HIV Infection**
1-2 P.M.—VA Medical Center, Lyons (*AMNJ and NJSDOH*)
- 7 **Clinical Management of HIV Infection**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove (*AMNJ and NJSDOH*)
- 13 **Counseling and Testing for HIV Infection**
8-9 A.M.—Underwood Memorial Hospital, Woodbury (*AMNJ and NJSDOH*)
- 14 **Counseling and Testing for HIV Infection**
8-9 A.M.—Passaic County Medical Society, Clifton (*AMNJ and NJSDOH*)
- 21 **Clinical Management of HIV Infection**
11:30 A.M.-12:30 P.M.—Rahway Hospital, Rahway (*AMNJ and NJSDOH*)

January

- 11 **Counseling and Testing for HIV Infection**
11:30 A.M.-12:30 P.M.—Rahway Hospital, Rahway (*AMNJ and NJSDOH*)
- 11 **Clinical Management of HIV Infection**
1:30-2:30 P.M.—Roosevelt Hospital, Metuchen (*AMNJ and NJSDOH*)
- 20 **Counseling and Testing for HIV Infection**
9-10 A.M.—Union Hospital, Union (*AMNJ and NJSDOH*)

MEDICINE

December

- 2 **Thermography**
11:30 A.M.-12:30 P.M.—St. Lawrence Rehabilitation Center, Lawrenceville (*St. Lawrence Rehabilitation Center*)
- 2 **Hyperlipidemia**
12 noon-1 A.M.—Bridgeton Hospital, Bridgeton (*Bridgeton Hospital*)
- 2 **Developmental Disabilities: Specific Dysfunctions**
1-2 P.M.—Woodbine Developmental Center, Woodbine (*AMNJ*)
- 6 **Antibiotics and Renal Disease**
9-10 A.M.—Holy Name Hospital, Teaneck (*Holy Name Hospital*)
- 6 **Problems in Neoplastic Management**
7-8 P.M.—West Hudson Hospital, Kearny (*West Hudson Hospital*)
- 7 **Living Wills**
10:30-11:30 A.M.—Christ Hospital, Jersey City (*AMNJ*)
- 7 **Early Office Recognition of Depression**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove (*AMNJ*)
- 7 **New Dimensions in Medical Education**
Learning Center, Englewood Hospital, Englewood (*Association for Hospital Medical Education of New Jersey*)
- 8 **Conservative Management of Osteoarthritis and Indications for Total Joint Arthroplasty**
11 A.M.—St. Joseph's Hospital and Medical Center, Paterson (*St. Joseph's Hospital and Medical Center*)
- 9 **How To Live To Be 106**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton (*Bridgeton Hospital*)
- 13 **The Pharmacologic Management of Pain**
9-10 A.M.—Holy Name Hospital, Teaneck (*Holy Name Hospital*)
- 13 **Nutritional Support**
12 noon-1 P.M.—Hospital Center at Orange, Orange (*AMNJ*)
- 14 **Emphasis on Significant Length and Quality of Life as Preconditions for Approval for Organ Transplantation**
1-2 P.M.—West Hudson Hospital, Kearny (*West Hudson Hospital*)
- 14 **Organ Procurement—Clinical Aspects**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic (*AMNJ*)
- 14 **How To Heal a Broken Heart**
6:15-9 P.M.—Perona Farms,

THE PHILADELPHIA HEART INSTITUTE
of Presbyterian—University of Pennsylvania Medical Center

CARDIOLOGY UPDATE

designed for the physician and provides an intensive survey of the
current status of clinical cardiology

Wednesday
December 7, 1988
3:00-5:00 PM

**Prevention and Management of
Acquired Heart Disease**

Moderator
Bernard L. Segal, M.D.

- 3:00-3:30** Which lipid lowering agents are appropriate for patients with
hyperlipidemia and when? Garo S. Garibian, M.D.
3:30-4:00 When is cardiac catheterization not indicated before surgery
in acquired cardiac disease? Jan R. Weber, M.D.
4:00-5:00 Case Presentations Barbara Kong, M.D.
Panel Discussion Jai B. Agarwal, M.D.
Harold R. Kay, M.D., Peter G. Lavine, M.D.
J. David Ogilby, M.D.

- No Registration Fee
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* The University of Pennsylvania School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing education for physicians. The University of Pennsylvania School of Medicine designates this continuing medical activity for 2 credit hours per session in Category I of the Physicians Recognition Award of the AMA.

Sussex County
(Hackettstown Community
Hospital)

- 16 Burns**
2-3 P.M.—Woodbridge
Developmental Center, Woodbridge
(AMNJ)
- 16 Combined Oral/Insulin Therapy of
Diabetes**
12 noon-1 P.M.—Bridgeton Hospital,
Bridgeton
(Bridgeton Hospital)
- 23 Anaerobic Infections**
7:30-8:30 A.M.—Atlantic City
Medical Center, Atlantic City
(AMNJ)

January

- 3 Seizure Disorders**
7-8 P.M.—West Hudson Hospital,
Kearny
(West Hudson Hospital)
- 11 Internal Medicine Review Course**
4-7 P.M.—University Hospital,
New Brunswick
(AMNJ)
- 11 Chronic Pain Management and
Issues Related to Iatrogenic
Addiction**
10:30-11:30 A.M.—St. Mary's
Hospital, Passaic
(AMNJ)
- 17 Arthritis**
10-11 A.M.—Green Brook Regional
Center, Green Brook
(AMNJ)
- 18 Migraine Headaches**
1-2 P.M.—West Hudson Hospital,
Kearny
(West Hudson Hospital)
- 20 Update in Arthritis**
12 noon-1 P.M.—Bridgeton Hospital,
Bridgeton
(Bridgeton Hospital)
- 24 Management of Abdominal
Emergencies**
11 A.M.-12 noon—Hunterdon
Developmental Center, Clinton
(AMNJ)
- 25 Hypertension**
10:30-11:30 A.M.—Christ Hospital,
Jersey City
(Christ Hospital)
- 26 Visiting Professor Program**
1:30-5 P.M.—Saint Barnabas
Medical Center, Livingston
(Saint Barnabas Medical Center)
- 27 Pain Management in Geriatrics**
12 noon-1 P.M.—Bridgeton Hospital,
Bridgeton
(Bridgeton Hospital)

OBSTETRICS/GYNECOLOGY

January

- 4 Laparoscopy and Colposcopy**
10:30-11:30 A.M.—St. Mary's
Hospital, Passaic
(AMNJ)
- 13- Second Annual Practical**
- 15 Approaches to Reproductive
Endocrinology and Infertility**
7 A.M.—San Juan, Puerto Rico
(UMDNJ)

ONCOLOGY

December

- 1 Cancer Research Colloquium**
- 8 3-4 P.M.—New Jersey Medical
School, G-506B, Newark
(UMDNJ)**
- 22 29**
- 7 Unproved Dietary and Nutritional
Methods in Cancer Prevention
and Treatment**
9-10:30 A.M.—Somerset Medical
Center, Somerville
(Somerset Medical Center)
- 7 Annual Clinical Abstract Meeting**
1:30-5 P.M.—The Manor,
West Orange
(Oncology Society of New Jersey)
- 22 Tumor Board Conferences**
12 noon-1 P.M.—Newcomb Medical
Center, Vineland
(Newcomb Medical Center)

January

- 5 Cancer Research Colloquium**
- 12 3-4 P.M.—New Jersey Medical
School, G-506B, Newark
(UMDNJ)**
- 26 6 Update in Cancer Treatment**
12 noon-1 P.M.—Bridgeton Hospital,
Bridgeton
(Bridgeton Hospital)
- 10 Colon-Rectal Cancer**
12 noon-1 P.M.—The Hospital
Center at Orange, Orange
(AMNJ)
- 19 Options in Treatment of Breast
Cancer**
12 noon-1:30 P.M.—Somerset
Medical Center, Somerville
(Somerset Medical Center)

ORTHOPEDICS

January

- 18 Artificial Replacement of
Ligaments and Tendons**
10:30-11:30 A.M.—St. Mary's
Hospital, Passaic
(AMNJ)

PEDIATRICS

January

- 5 Child Abuse—Neglect**
11 A.M.-12 noon—St. Joseph's
Hospital and Medical Center,
Livingston
(AMNJ)

PSYCHIATRY

December

- 1 Grief Reactions and Linking
Objects**
12 noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)
- 2 Psychiatric Lecture Series**
- 9 1:30-3:30 P.M.—Trenton Psychiatric
Hospital, Trenton
(Trenton Psychiatric Hospital)**
- 7 Early Office Recognition of
Depression**
1:30-2:30 P.M.—Essex County
Hospital Center, Cedar Grove
(AMNJ)
- 7 Case Seminars To Improve**
- 14 Psychotherapeutic Technique**

8-10 P.M.—2 West Northfield Drive,
Livingston
(Advanced Psychiatric Study
Group)

- 8 Psychodynamic Observations on
Fathering**
12 noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)
- 15 Issues in the Treatment of
Adolescents**
12 noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)

January

- 4 Case Seminars To Improve**
- 18 Psychotherapeutic Technique**
8-10 P.M.—2 West Northfield Road,
Livingston
(Advanced Psychiatric Study
Group)
- 11 Drug Addiction—Chronic Pain
Management and Issues Related
to Iatrogenic Addiction**
10:30-11:30 A.M.—St. Mary's
Hospital, Passaic
(AMNJ)
- 27 Meeting of the NJ Psychiatric
Association and the NJ
Psychoanalytic Society**
8-10 P.M.—Atrium West,
West Orange
(NJ Psychoanalytic Society)

SURGERY AND SURGICAL SPECIALTIES

December

- 2 Surgical Management of Benign
and Malignant Disease of the
Breast**
7:30-8:30 A.M.—Freehold Area
Hospital, Freehold
(AMNJ)
- 3 37th Annual Clinical Meeting**
8:30 A.M.-4:30 P.M.—Berkeley
Carteret Hotel, Asbury Park
(American College of Surgeons)
- 6 Surgical Grand Rounds**
- 13 7-9 A.M.—Hackensack Medical
Center, Hackensack
(Hackensack Medical Center)**
- 20 21 Surgery—Alternatives to
Ileostomy and Colostomy**
10:30-11:30 A.M.—St. Mary's
Hospital, Passaic
(AMNJ)

January

- 3 Surgical Grand Rounds**
- 10 7-9 A.M.—Hackensack Medical
Center, Hackensack
(Hackensack Medical Center)**
- 24 Pediatric Reconstructive Surgery**
8-10 P.M.—Englewood Club,
Englewood
(Englewood Surgical Society)

UROLOGY

January

- 11 Urology Rounds**
6:20-8:30 P.M.—Robert Wood
Johnson Medical School, 108B,
New Brunswick
(UMDNJ)

NEW JERSEY MEDICINE

OPPORTUNITIES

CME
969-973

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LETTERS TO THE EDITOR

Carotid Vascular Disease; Hospital Corridor Prescribing; Not Just for Laughs

Carotid Vascular Disease

September 7, 1988

Dear Doctor Slobodien:

Drs. Bazewicz, Sandler, and Cohn make an important statement when they indicate that noninvasive cerebrovascular studies are of sufficient accuracy that they may preclude the need for diagnostic contrast imaging of internal carotid artery lesions in the June issue of *New Jersey Medicine*.¹ They utilized oculoplethysmography (OPG), doppler spectral analysis (SA), supraorbital bidirectional doppler flow studies (SOF), and B-mode imaging for evaluations. Our laboratory has supplemented these studies with carotid phonangiography (CPA). CPA utilizes an electronic stethoscope with a graphic analysis to evaluate carotid bruits.² The degree of stenosis can be estimated by the characteristics of the bruits. Diastolic bruits indicate a stenosis of greater than 85 percent. Pan-systolic bruits indicate a stenosis of 40 to 85 percent, depending upon the pitch of the bruits, the higher pitched bruits correlating with a greater stenosis. Short systolic bruits usually indicate a lesser degree of stenosis. We have found that CPA provides important supplemental information in the nonin-

vasive evaluation of the carotid circulation.

(signed) Mahmud Bangash, M.D.

Bruce M. Burtan, M.D.

Joel F. Lehrer, M.D.

Judy MacDonald, R.N.

Marie Eschbacher, R.N.

Holy Name Hospital

REFERENCES

1. Bazewicz RA, Sandler LB, Cohn JD: Clinical correlates and diagnostics in carotid vascular disease. *NJ Med* 85:497-501, 1988.

2. Kartchner MM, McRae LP: Auscultation for carotid bruits in cerebrovascular insufficiency. *JAMA* 210:494-497, 1976.

Hospital Corridor Prescribing

August 22, 1988

Dear Doctor Slobodien:

As president of the New Jersey State Board of Medical Examiners, I wish to echo the advice and concern expressed in the August issue of *NEW JERSEY MEDICINE* concerning hospital corridor prescribing (page 644).

This Board has had to investigate physicians who have prescribed controlled dangerous substances to hospital personnel during corridor meetings. The investigations have revealed that the prescribing is done without proper physical or history examination, and patient records are not prepared. The physician later has discovered that he was duped in that the "patient" also was receiving medication in a familiar manner from other physicians in the hospital. Physicians should avoid the temptation of accommodating a colleague or other health care professionals by prescribing contrary to good medical practice. Such corridor encounters should alert physicians to this problem which might lead to the aiding and abetting of a drug-dependent person.

(signed) Frank J. Malta, M.D.

Not Just for Laughs

Dear Doctor Slobodien:

One of the greatest problems that we face in promoting our good intentions is the limited attention span of our busy colleagues.

With this in mind, I have long striven to develop one-liners, which would "say it all." Some of those attempts have endeared me to those who shared my viewpoint, and

further antagonized the targets of my barbs. In either case, it got their attention!

We live in a world of acronyms. In our patient education duties we should explain that while chicken soup may have a therapeutic value, alphabet soup can often be hazardous to their health.

Making up alternative definitions for the multitude of initials with which we daily deal can be a relaxing diversion. I intend to write a book on the subject, but I do not mind sharing a few of them with you.

There have been numerous twists on DRGs, but my original version, "danger of regulation by government," sounds better as time goes by.

You must all be familiar with the recent flap over including the RAPs (radiologists, anesthesiologists, and pathologists) under hospital DRG payments. Emergency room (ER) physicians originally were included as part of the package. They were eventually excluded, not because of any benevolent consideration, but more likely because that acronym would have more accurately described the process as RAPE.

As second, third, and fourth generation derivatives of HMOs have evolved, but listing them all, with the inevitable "etc." to cover those which surfaced between writing and publication, has wasted a lot of space. My solution is to refer to all as HMOs and OOPs. OOPs are defined as "other objectionable programs." OOPs, as a word, is defined in the dictionary as an expression, used typically to express mild apology, surprise, or dismay. I find that most fitting.

The latest entry, SHMOs, supposedly stands for social health maintenance organizations. They had me fooled for awhile, since I thought the program had been named for its originators.

My major project, in this vein, is to encourage people to refer to socialized medicine as S&M. To any of you who are unfamiliar with kinky sex or psychiatry, S&M is the abbreviation for sadism and masochism. Think about it. What better or clearer way is there to characterize this impending atrocity?

If you have any personal favorites, please pass them along to me.

(signed) Frank J. Primich, M.D.

Current Trends in Urology; Dentistry, A Historical Perspective; Interventional Radiology; Magnetic Resonance Annual; Magnetic Resonance Imaging; Management of Ocular, Orbital, and Adnexal Trauma; Sports Science Perspectives for Women

Current Trends in Urology, Volume 4

Martin I. Resnick, M.D., (ed). Baltimore, MD, Williams and Wilkins, 1988 Pp. 190. (\$48.50)

It is hard to believe another book dealing with new problems in urology could serve a useful purpose, but this text does. Dr. Resnick and outstanding experts have written about ten of the major problems in urology. Tom Lue summarizes the current thought on impotence therapy. Barry Stein discusses the laser. Donald Bodner writes about spinal cord injuries. William Catalona describes the nerve sparing radical prostatectomy. Drs. Zekan and Muss give us the current thinking on systemic chemotherapy, and Drs. Kowalkowski and Lamm do the same for intravesical chemotherapy. Edward McGuire writes about female incontinence. Drs. Hursey, Doornbos, and Jani describe radiation therapy for cancer of the prostate (in rather too much detail for most urologists). Drs. Olssen, Benson, Sawczuk, and Blaivas give their views and techniques of bladder substitution, and Paul Lange comments on testicular tumors.

Much of the literature is summarized here in a generally practical and common sense way. I felt I learned something from this book, and I think other urologists will, too.

Robert Zufall, M.D.

Dentistry, A Historical Perspective

Milton B. Asbell. Bryn Mawr, PA, Dorrance & Company, 1988. (\$24.95)

Written by a scholar who is the dean of dental historians in New Jersey and a recognized national authority, this book marks the culmination of many years of study devoted to the rise of dentistry throughout the ages. Although primarily interested in the dental history of our own country, Dr. Asbell takes us back to antiquity and through the Middle Ages and Renaissance, down to modern times.

By the 17th century, teeth already were becoming the subject of increasing scientific scrutiny and the qualifications of the surgeon-dentist as opposed to the barber and quack were being supervised carefully by the College de Saint-Come in Paris. But the rise of dentistry as a modern specialty can be traced to the work of Pierre Fouchard whose pivotal work, *Le Chirurgien Dentiste*, (1728) was widely translated and became the classic approach to the subject.

The major portion of the book is devoted to a highly detailed account of the development of dental science in our own country. Beginning with the colonial period, the author traces the progress in dental care; the opening of the first school in the world devoted to this specialty in Baltimore in 1840; the use of nitrous oxide in extractions (1840); and other major improvements. We can all take pride in the enormous advances in dentistry resulting from Yankee ingenuity. This book is highly recommended to everyone who would like to know more about American contributions to the preservation of the teeth.

Morris H. Saffron, M.D., Ph.D.

Interventional Radiology

Wilfredo Castañeda-Zuinga and S. Murthy Tadovarthi. Baltimore, MD, Williams & Wilkins, 1988. Pp. 1,250. (\$125)

This volume, the latest addition to the extensive series known as the

golden diagnostic series, places more emphasis on the philosophy of interventional radiology than on its specific techniques; however, those techniques do receive attention.

After opening with a discussion of the use of extracranial embolization and ablative therapy in the body, the text reviews both angioplasty and fibrolytic techniques. IVC filters and the intravascular removal of foreign bodies figure in the discussion of the vascular system. The discussion of interventional genitourinary radiology is thorough and especially good. Newer areas such as the use of ferromagnetic microembolization, laser angioplasty, and dilation of gastrointestinal strictures are included.

The very well-written text is accompanied by excellent radiographs, photographs of equipment (catheters and guidewires), and line drawings. Each well-researched topic provides background descriptions about the design as well as brief accounts of the related techniques and their followup, noting possible complications.

Overall, the book does fulfill its purpose admirably. Although the physician who wishes to learn the techniques in greater detail may wish to consult its bibliography, *Interventional Radiology* plays an essential role for the physician in search of greater understanding of the field as a whole.

Neil B. Horner, M.D.

Magnetic Resonance Annual 1988

Herbert Y. Kressel, M.D., (ed). New York, NY, Raven Press, 1988. Pp. 357. (\$73)

This volume is fourth in an annual series of monographs providing excellent reviews of the field of magnetic resonance imaging (MRI). The series has continued to present clinical as well as theoretical developments of MRI.

The clinically oriented chapters discuss diseases of the knee joint, hip joint, temporomandibular joint (TMJ), and the heart. The format is similar for all these areas; a review of normal anatomy is followed by a description of pathological entities. The section about TMJ especially is well done and includes many high-quality illustrations. One of the chapters gives focus to gadolinium,

which recently won approval as a contrast agent; herein is a presentation of its pharmacokinetic properties, its appearance at different pulse sequences, and its use for the entire body.

In addition to describing technical innovations, this consistently well-written text takes up the topic of MR artifacts, rapid MR techniques, and cerebrospinal fluid flow-physiology.

The book is highly recommended to the physician who wishes both clear and concise discussions of the advances in the field.

Neil B. Horner, M.D.

Magnetic Resonance Imaging

David D. Stark, M.D., William G. Bradley, Jr., M.D., Ph.D., (eds). St. Louis, MO, C.V. Mosby, 1988. Pp. 1,546. (\$140)

The editors of this large text have produced a superior book, encompassing the wide scope of current magnetic resonance imaging (MRI). The review of the physical principles, for example, spans 20 chapters and includes a discussion that ranges from flow principles to safety considerations. Although they are presented with clarity, several chapters are expressed in a more complex manner than the average physician might desire in the way of introduction.

The imaging of the body is approached in a two-part manner; the central nervous system and the remainder of the body. The brain and spine are reviewed extensively in terms of different disease entities including ischemia, multiple sclerosis, and hemorrhage; a separate chapter is devoted to pediatric disorders.

The "body" section includes head

and neck disorders; it discusses cardiac imaging as well as diagnostic study and obstetrics; again, a chapter is set aside for pediatric disorders.

The chapters are impressive for their thorough research and for their range. The high-quality scans make liberal use of line drawings and computed tomography scans.

To best describe this text, one must say that it is excellent encyclopedia, and a boon to the physician involved in the field.

Neil B. Horner, M.D.

Management of Ocular, Orbital, and Adnexal Trauma

Thomas C. Spoor, M.D., and Frank A. Nesi, M.D., (eds). New York, NY, Raven Press, 1988. Pp. 445. (\$88.50)

Management of ocular trauma certainly is an important topic in ophthalmology. Effective management often is a multidisciplinary task. The authors of this text bridge the gap between specialties. Consistent with the background of the editors, a major part of the book deals with orbital and neuro-ophthalmologic trauma. Extremely important is the chapter on neuro-ophthalmologic manifestations. Dr. Spoor's diagrams of the neural pathways and visual fields are excellent.

In general, the text contains excellent diagrams, but some of the photographs lack proper contrast. The chapter on ultrasonography in trauma especially is informative. The only drawback is that found in any multiauthored text: many of the sections contain repetitive material. This may cause the reader to skip over important sections.

In summary, the editors of this

text make an important contribution to the ophthalmic literature by presenting an updated, multidisciplinary approach to the management of ocular trauma. This book is a good addition to any reference library, and is useful for anyone dealing with ocular and orbital trauma.

Donald J. Cinotti, M.D.

Alfonse A. Cinotti, M.D.

Sports Science Perspectives for Women

Jacqueline L. Puhl, Ph.D., C. Harmon Brown, M.D., Robert O. Voy, M.D., (eds). Champaign, IL, Human Kinetics Books, 1988. Pp. 248. (\$28)

For the neophyte in sports medicine or the medical specialist unfamiliar with aspects of the field not normally encountered in practice, *Sports Science Perspectives for Women* is an excellent text. It concisely covers the physiological, psychological, physical therapy, and training and conditioning aspects of sports medicine as well as reviews such topics as injuries, pregnancy, and menstrual disorders seen specifically in the female athlete.

The nutritional concerns of the athlete with special emphasis on the eating disorders and obesity problems in the female athlete also are addressed in some detail.

Although familiar with most of the topics in the text, the reviewer found the book to be a good update on the topics discussed and gleaned some new material of note.

The book is worth having on the shelf in any physician's office who deals with active, athletic females, as a quick reference and as an aid in problem solving for patients.

Christine E. Haycock, M.D.

***Drs. Del Guercio;
Dell'Aquila; Dimun; Duty;
Hawes; Inge; Sawchuck;
Seymour; Stewart***

Medicine, Italy, in 1960. He completed an internship at Presbyterian Hospital, Newark, in 1962. Dr. Dell'Aquila was a member of our Essex County component; he was affiliated with West Hudson Hospital, Kearny.

Dr. John T. Dimun

John Theodore Dimun, M.D., 82, died on August 18, 1988. Born in 1906 in Trenton, Dr. Dimun received his medical degree from the University of Pennsylvania Medical School in 1931. He completed his residency training at St. Francis Hospital, Trenton, and in 1957 became chief of medical services for the hospital. He had a private practice in his hometown since 1932, and was a consultant for the Department of Medicine at St. Francis Hospital until 1986. Dr. Dimun was a member of our Mercer County component and of the American Medical Association.

Dr. Edward R. Duty

Edward Richard Duty, M.D., a psychiatrist from Morristown, died on August 16, 1988. Born in 1925 in Arkansas, Dr. Duty received his medical degree from the University of Arkansas School of Medicine in 1948. He was director of psychiatry at Bergen Pines County Hospital, and affiliated with Fair Oaks, Inc., as clinical director. Dr. Duty was a member of our Morris County component, of the American Psychiatric Association, of the American Medical Association, and of the Arkansas Medical Society.

Dr. Vernon L. Hawes

Retired Ramsey family physician Vernon Lee Hawes, M.D., 82, died on June 18, 1988. Born in Rose Hill, North Carolina, Dr. Hawes received his medical degree from Jefferson Medical College of Philadelphia, Pennsylvania, in 1929. He practiced medicine in Ramsey from 1930 until 1970, and was the borough's school and sports physician. Dr. Hawes also maintained affiliations with The Valley Hospital, Ridgewood, and Hackensack Medical Center. He was a U.S. Army veteran of World War II, having served in the medical corps as a major. Dr. Hawes was a member of our Bergen County component and of the AMA. He was a 1979 recipient of the Golden Merit Award.

Dr. Theodore R. Inge

Theodore R. Inge, M.D., a member of our Essex County component, died on August 8, 1988. Born in 1901, Dr. Inge was graduated from University of Minnesota Medical School in 1928. A surgeon and family practitioner, Dr. Inge was a member of the American Medical Association, and was the first black physician appointed to the staffs of General Hospital, East Orange, and Newark Beth Israel Medical Center. During his career, Dr. Inge was the police surgeon for the city of Orange, and senior attending physician of the Essex County Geriatrics Center. He received MSNJ's Golden Merit Award.

Dr. Steven Sawchuck

Word has been received of the death of Steven Sawchuck, M.D., a member of our Middlesex County component. Born in 1916, Dr. Sawchuck received his medical degree from Temple University School of Medicine, Philadelphia, in 1943. During his career, Dr. Sawchuck was affiliated with Johnson and Johnson, in New Brunswick. Dr. Sawchuck was a member of the American Medical Association, a diplomate of the American Board of Pediatrics, and a clinical assistant professor at Temple University.

Dr. Edward T. Seymour

Edward Thomas Seymour, M.D., died at the age of 88. Dr. Seymour received his medical degree in 1926 from Ohio State University Medical School. A family practitioner from Tenafly, Dr. Seymour was affiliated with Englewood Hospital; he was a member of our Bergen County component and of the American Medical Association. At the time of his death, Dr. Seymour was retired and residing in Nashville, Tennessee.

Dr. Robert G. Stewart

Robert George Stewart, M.D., a retired member of our Essex County component died in February 1988. Born in 1895, Dr. Stewart received his medical degree from Cornell Medical School, New York, in 1921. During his career, Dr. Stewart was affiliated with The Mountainside Hospital, Montclair, as a surgeon; he was a member of the American Medical Association.

Dr. Olindo Del Guercio

Retired for 20 years from gynecology practice, Olindo Del Guercio, M.D., 89, died on June 7, 1988. Born in Teora, Italy, Dr. Del Guercio received his medical degree in 1923 from the Faculty of Medicine, University of Naples, Italy. He emigrated to the United States in 1926, and became affiliated with St. Michael's Medical Center, Newark. Dr. Del Guercio was a veteran of both World Wars, serving in the Italian army during World War I, and the United States Army during World War II. He was a member of our Essex County component and of the AMA. In 1973, Dr. Del Guercio received the Medical Society of New Jersey's Golden Merit Award, in recognition of his 50 years of medical practice.

Dr. Richard N. Dell'Aquila

Word has been received of the death of family practitioner Richard Nicholas Dell'Aquila, M.D. Born in 1932 in Newark, Dr. Dell'Aquila was awarded a medical degree from the University of Bologna School of

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2. Mail subscriptions	9,993	9,629
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D. Free distribution by mail carrier or other means—samples, complimentary, and other free copies	589	589
E. Total distribution (sum of C and D)	10,582	10,218
F. Copies not distributed		
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G. Total (sum of E, F1, and 2—should equal net press run shown in A)	10,802	10,438

11. I certify that the statements made by me above are correct and complete.
(signed) Arthur White

Director of Finance and Administrative Services

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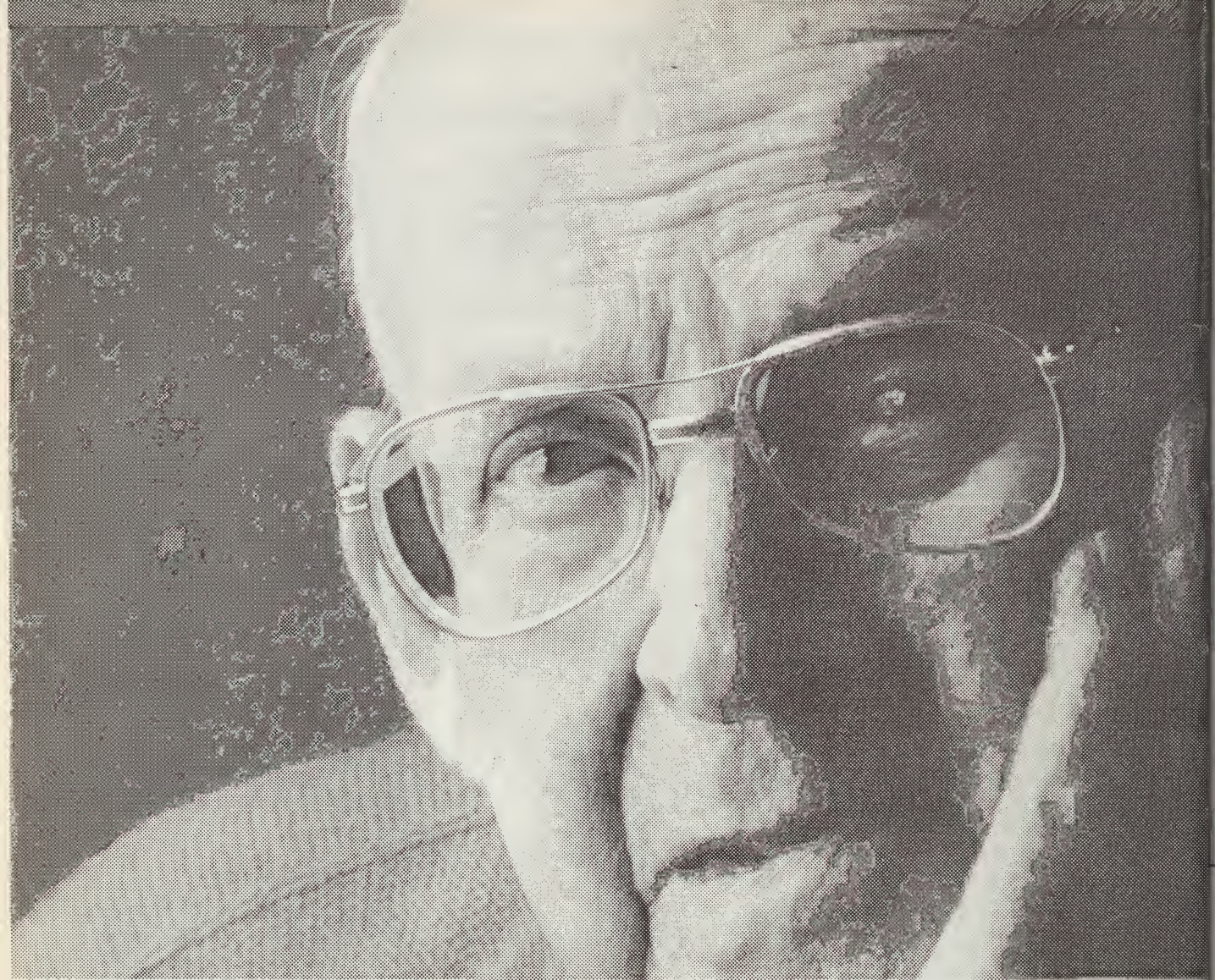
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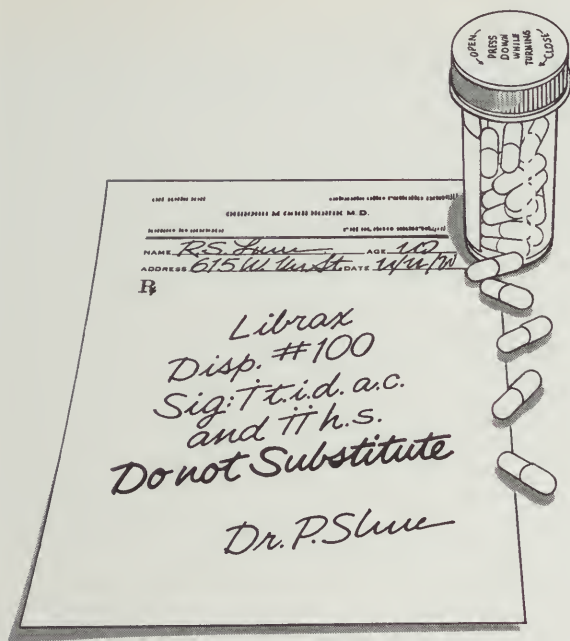
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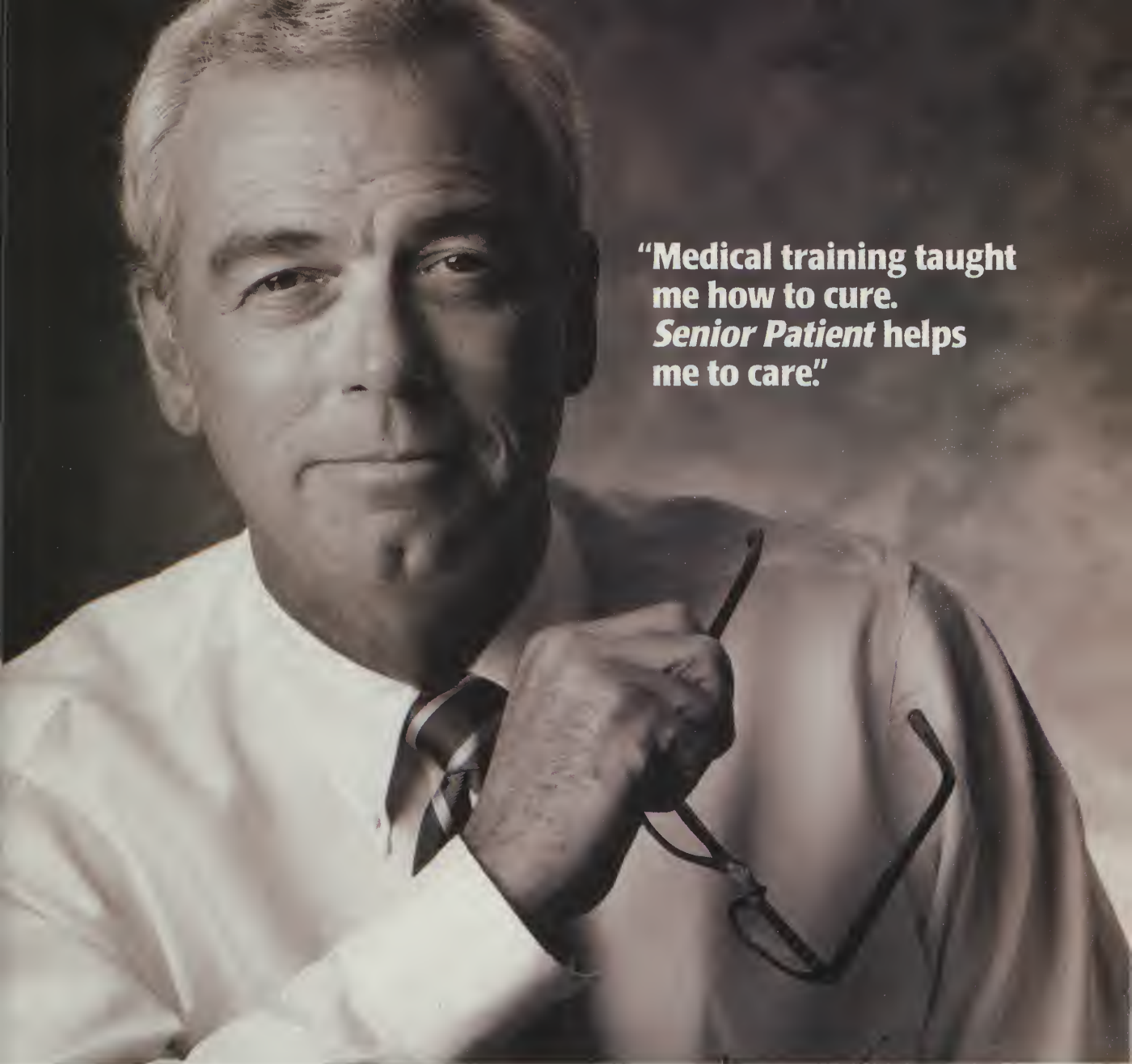
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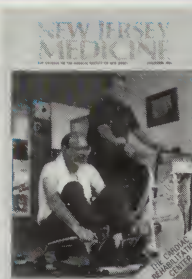
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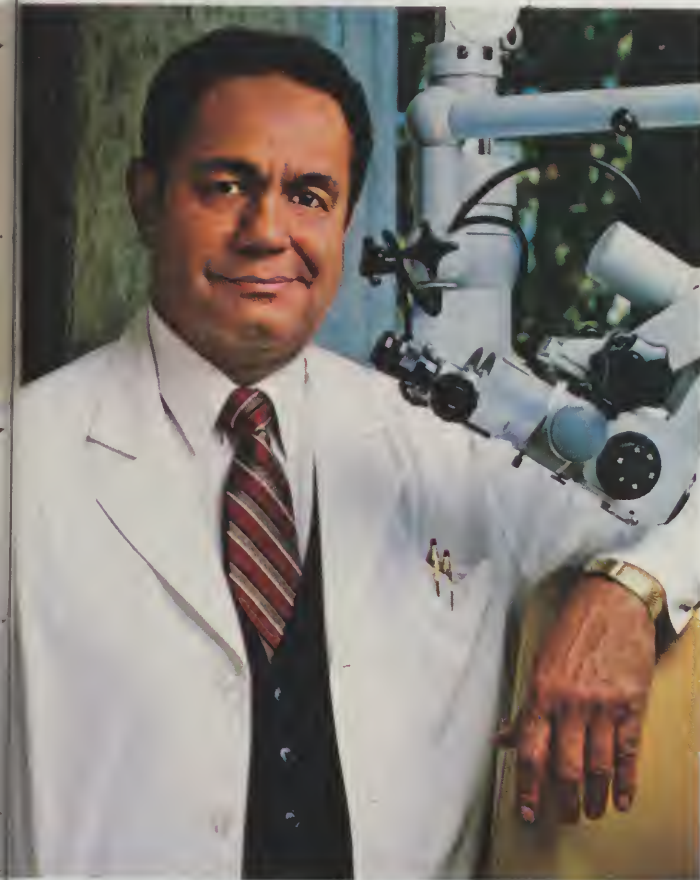
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On The Cover: Lou Fischer and Noubar Varjebidian participate in a cardiac rehabilitation program. The complete story begins on page 1017. Cover: Stan Godlewski.





DALE L. TIPTON, M.D.

Associate Clinical Professor, Department of Otolaryngology, Head and Neck Surgery, University of California School of Medicine, San Francisco, California.
Chairman, Division of Otolaryngology, Franklin Hospital, San Francisco, California.
Lieutenant Colonel, U.S. Army Reserve.

EDUCATION University of California at Berkeley, A.B. Physiology; University of California School of Medicine, San Francisco, M.D. and Master of Science, Pharmacology.

RESIDENCY University of California School of Medicine, San Francisco: General Surgery—2 years; Otolaryngology—3 years.

FELLOWSHIPS National Institute of Health Fellow; Cancer Research Institute, University of California, San Francisco.

OUTSTANDING ACHIEVEMENTS Freshman Medical Student Research Award; Class President—2nd year medical school; Student Body President—senior year medical school; Special Award by National Institute of Health to attend and present paper at International Congress of Otolaryngology in Tokyo, Japan; Chairman, Department of Otolaryngology, San Francisco General Hospital 1970-76; Chief of Medical Staff, Franklin Hospital 1982-84.



Dr. Tipton and residents examining post-operative patient in recovery room.

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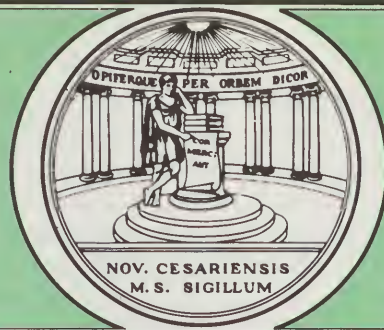
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THE MEDICAL SOCIETY OF NEW JERSEY

Volume 61

1989 MSNJ ANNUAL MEETING

Wednesday, April 26, 1989

3:30 P.M. Board of Trustees' Meeting

Thursday, April 27, 1989

8:00 A.M. Registration Opens

8:00 A.M. Message Center Opens

10:00 A.M. House of Delegates

1:00 P.M. Program—Topic of Major Interest to Physicians

1:00 P.M. Exhibits Open

3:30 P.M. Reference Committee Meetings

Friday, April 28, 1989

8:00 A.M. Registration Opens

8:00 A.M. Message Center Opens

8:30 A.M. Exhibits Open

9:00 A.M. House of Delegates (Election)

12:00 NOON Golden Merit Award Ceremony and Reception

2:30 P.M. Reference Committee Meetings

5:00 P.M. JEMPAC Political Forum

5:45 P.M. JEMPAC Wine and Cheese Reception

6:30 P.M. Middlesex County Medical Society Reception

Saturday, April 29, 1989

8:00 A.M. Registration Opens

8:00 A.M. Message Center Opens

8:30 A.M. Exhibits Open

9:00 A.M. House of Delegates

1:30 P.M. House of Delegates

2:00 P.M. Exhibits Close

6:00 P.M. Inaugural Reception and Dinner

Sunday, April 30, 1989

8:00 A.M. Registration Opens

8:00 A.M. Message Center Opens

8:30 A.M. General Session—Topic of Major Interest to Physicians

1:00 P.M. Board of Trustees' Meeting

PHYSICIAN PAYMENT REVIEW COMMISSION

Physician Data Survey

The Physician Payment Review Commission is an advisory body to the U.S. Congress composed of prominent physicians and health policy experts. It was created by Congress in 1986 to make recommen-

dations to reform Part B of Medicare. The Commission is conducting a survey of physicians to obtain data that will be used in the preparation of the Commission's March 1989 report to Congress. We are writing to state and county medical societies, as well as to national specialty societies, to briefly describe this study.

The main purpose of the survey is to obtain data not available from other studies on practice costs, Medicare assignment patterns, the use of certain diagnostic services, and the allocation of physicians' time. The data then will be used to develop recommendations on Medicare reimbursement and other issues. This survey is one of the ways in which physicians will have direct input into the process of reforming the Medicare program.

Westat, Inc., the company selected to perform this study, will contact a random sample of approximately 6,000 physicians and request their participation in this study. Each physician will receive a copy of the survey and an explanation of its purpose. Physicians who respond will have the option of mailing back the completed survey or providing information over the telephone to trained interviewers. We have worked with Westat to minimize the burden of responding to this survey.

AMERICAN BOARD OF MEDICAL SPECIALTIES

FMG Residents Provide Service

A study by Policy Analysis, Inc. as reported in *Hospitals* suggests that FMG residents provide services which would be expensive to replace. The study examined the cost of replacing FMG residents at 15 FMG-dependent teaching hospitals and estimated that it would cost between \$10,000 and \$75,000 per resident to replace them. Residency programs with more than ten physicians of which 25 percent or more are FMGs were so classified. The average hospital surveyed would stand to lose from \$2 million to \$5 million a year in Medicare funds which represent funding for the percent of lost Medicare patient days and the Medicare resident per bed add-on which teaching hospitals receive. The question raised by this study is, of course, whether the residency programs are designed specifically for training or whether this is an additional bit of evidence that residency programs are to provide "cheap" labor in public funded hospitals.

POSITION OF THE AMERICAN MEDICAL ASSOCIATION
Saving Human Life Through Animal Research

Background. The AMA has supported the proper and humane use of animals in research for more than 100 years. The Association opposes legislative and regulatory initiatives that inappropriately would restrict biomedical research.

An estimated 12 to 15 million animals are used each year in research projects. Some 75 percent to 90 percent of those animals are rodents, many used in studies of blood substances, such as hormone production, neurotransmitter regulation, and other substances involved in maintaining homeostasis.

Despite the judicious use of animals in research, many groups of "animal rights" activists urge an end to all scientific investigation that involves animals. Animal welfare and humane societies promote research limitations aimed at reducing the number of animals used, or at exempting certain animals from research projects.

These efforts have resulted in the destruction or termination of many valid investigations. They also have promoted passage of federal and state laws that regulate or restrict the use of animals in research.

Position. The AMA maintains that the loss of biomedical animal research would hamper severely the remarkable growth of knowledge this nation has experienced in recent decades. Medical breakthroughs in diagnosis, treatment, and prevention of heart disease, cancer, diabetes, measles, and many other diseases can be traced directly to the use of animals in research.

Procedures once beyond imagination are commonplace today: open-heart surgery, blood transfusions, organ transplantation, and laser neurosurgery. All were made possible by animal investigations. Crucial to control of the AIDS epidemic will be animals used in research.

While cases of abuse have been documented, the evidence demonstrates that the overwhelming use of animals in investigations complies with federal, state, local, and institutional guidelines, and is conducted with strict compliance to ethical guidelines.

POSITION OF THE AMERICAN MEDICAL ASSOCIATION
Caring for the Needy Elderly

Background. The AMA strongly encourages physicians to accept Medicare's approved payment as payment-in-full for needy beneficiaries. Indeed, the physician acceptance rate in the third quarter of last year was 74.6 percent of claims. Three-fourths of the claims were accepted at Medicare's reimbursement level rather than at the private reimbursement level.

Despite this positive evidence of physician responsibility in caring for the needy elderly, several states have introduced legislation that would force physicians to accept Medicare's reimbursement level as payment-in-full. One state, Massachusetts, has made Medicare mandatory assignment for all beneficiaries a condition of licensure for physicians.

Position. The AMA supports a voluntary program for caring for the needy elderly. The Association has assisted medical societies across the nation in launching such programs. They help beneficiaries locate physicians who will accept assignment, and each program is designed to meet local needs and circumstances. The programs build upon community resources already in place.

AMA data indicate that physicians are responding positively. Since 1982, the percentage of physicians caring for Medicare beneficiaries has climbed 30 percent, from 56 percent to 86 percent. Acceptance of assignment of claims increased from 52.8 percent to 74.6 percent during the same period.

Furthermore, it should be noted that not all elderly are needy. Approximately 12 percent of the elderly lived below the poverty level in 1985, compared with 14 percent of the rest of the population.

Thus, the AMA believes it is unnecessary and unfair to require assignment of all Medicare claims. The more affluent elderly clearly can afford to pay the difference between Medicare reimbursement and the full amount charged to private patients.

**AMERICAN BOARD OF MEDICAL SPECIALTIES
AMA Position on Licensing FMGs**

An AMA policy adopted at the 1988 annual meeting states that "all physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character," and not the country in which the medical school they attended is located (*Health Professions Report*, July 1, 1988).

**AMERICAN MEDICAL ASSOCIATION
Medical Practice Arrangements**

AMA survey data show that physician participation in alternative delivery systems, i.e. HMOs, PPOs, ACCs, is increasing. Growth has been observed in the proportion of physicians having contracts with alternative delivery systems and in the importance of such contracts to physicians' practice revenues. The proportion of physicians choosing to join alternative delivery systems should continue to grow.

POSITION OF THE AMERICAN MEDICAL ASSOCIATION
Assuring an Adequate Supply of Physicians

Background. The AMA supports a wide array of financial aid programs for qualified medical students to assure equal opportunity for all. The high costs of medical education are making it increasingly difficult for any other than the wealthy to gain training. The Association believes that this is not good for the health of the nation.

Right now three major federal loan programs provide financial assistance to medical students: The Health Professions Student Loan (HPSL); Health Education Assistance Loan (HEAL); and Guaranteed Student Loan (GSL) programs. They provide subsidized loans from funds capitalized by the government; federal insurance for market-rate loans; and direct loans at subsidized rates.

The Higher Education Act Amendments of 1986 (P.L. 99-498) assured continued federal support for five years. GSL limits were raised from \$2,500 to \$2,625 for the first two years; from \$2,500 to \$4,000 for the second two years; and from \$5,000 to \$7,500 for postgraduate study. However, now applicants must demonstrate financial need. In addition, deferment provisions are provided for full residency training only for physicians in institution-based programs and not in community-based programs.

Position. The AMA believes that loan deferments should be provided to all medical residents for the duration of their postgraduate training. The deferment should be provided regardless of where or when loans were received, where residency training occurred, or how long the training lasted.

It is not uncommon for medical school tuition to exceed \$10,000 per year. Residents typically are paid modest salaries. Thus, with the large amount of debt usually accumulated, it is financially burdensome for most residents to begin loan repayment before completion of residency training.

AMA Research. Traditionally, physicians have practiced in solo, sole proprietorship, fee-for-service practices. With the emergence of alternative delivery systems and the restructuring of the health care finance system, the traditional motivating forces for entering into a given type of practice arrangement have changed. AMA's Center for Health Policy Research examined these changes by utilizing data generated from the Association's Socioeconomic Monitoring System (SMS) to delineate the changes in physicians' practice arrangements across three dimensions: delivery system—ambulatory care centers (ACC), health maintenance organizations (HMO), and preferred provider organizations (PPO); form of legal organization of the practice; and practice size (in terms of the number of physicians in the practice).

The research was conducted by David W. Emmons, Ph.D. The study focused on the changes in the type of medical practice arrangements being entered into by physicians between the years 1983 and 1986. Some of the factors discussed which may influence how a physician establishes his practice include the legal and financial responsibility that the physician will bear, the capital costs associated with a practice, and access to patient bases.

Research Findings. In general, the research findings document the nature and extent of the change in physicians' practices:

The percentage of physicians receiving revenues from HMOs or IPAs increased from 27.3 percent in 1984 to 34.8 percent in 1986. In addition, the survey indicated that in 1986, 42.2 percent of the physicians had HMO contracts.

Among those receiving IPA or HMO revenues, the proportion of such revenues to total practice revenues also increased. Between 1984 and 1986, the number of physicians who received less than 5.0 percent of their revenues from HMOs dropped from 48.6 percent to 35.3 percent. The number of physicians who re-

ceived more than 10.0 percent from HMOs increased from 3.7 percent to 6.7 percent.

The percentage of physicians with PPO contracts has increased: from 10.9 percent in 1983 to 38.3 percent in 1986. Past numbers regarding this statistic were deceiving, as a measure of physician involvement, due to the frequency with which physicians contracted with a PPO yet did not receive any PPO revenues. This no longer is the case: the percentage of physicians who had contracts with a PPO but received no revenue from the PPO decreased from 26.1 percent in 1984 to 12.4 percent in 1986.

The growth in the percentage of physicians in incorporated practices has been reversed as a result of measures like the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA): the percentage of physicians who were incorporated decreased from 55.3 percent in 1983 to 49.6 percent in 1986. TEFRA eliminated several important tax advantages which previously had been afforded incorporated practices.

Despite the growth in group practice arrangements, and the perception held by some individuals that solo practices are becoming extinct, almost half of those surveyed still are in solo practices: 47.7 percent in 1986.

A number of conclusions is warranted based on the assembled data and its analysis. First, there is increasing physician participation in ACCs, HMOs, and PPOs. In addition, female physicians are playing relatively larger roles in these delivery systems than males. Second, the passage of TEFRA appears to have altered the trend toward incorporated practice. Finally, the shift from solo practice to group practice has stabilized, though the average size of group practices continues to increase.

If you have any questions, please contact: Office of Socioeconomic Research Information, American Medical Association, 535 North Dearborn Street, Chicago, IL 60610.

SINGLE PEOPLE

Total Income Including Social Security	Basic Premium*	Supplemental Income-Based Premium	Total Premium Per Enrollee
\$10,000 or less	\$48	\$0	\$48
\$20,000	\$48	\$180	\$228
\$30,000	\$48	\$405	\$453
\$40,000	\$48	\$720	\$768
\$50,000+	\$48	\$800	\$848

MARRIED COUPLES

Total Income Including Social Security	Basic Premium*	Supplemental Income-Based Premium	Total Premium Per Couple
\$20,000 or less	\$96	\$0	\$96
\$30,000	\$96	\$225	\$321
\$40,000	\$96	\$428	\$524
\$60,000	\$96	\$945	\$1,041
\$80,000	\$96	\$1,575	\$1,671
\$90,000+	\$96	\$1,600	\$1,696

*All enrollees pay the basic premium. Only those with incomes above certain levels pay an income-based "supplemental" premium.

NOTE: AARP estimates that 56% of Medicare enrollees would pay only the basic premium of \$48 per year. Other enrollees would pay the basic premium plus a supplemental premium; 24.4% would pay a total of less than \$250; 7% would pay \$250 to \$500. Only the remaining 12% would pay a total of over \$500 annually.

Source: AARP.

CATASTROPHIC COVERAGE

Medicare

January 1, 1989

■ Medicare provides unlimited hospital coverage after payment of an annual deductible, estimated at \$564 in 1989.

■ Coverage of acute care in skilled nursing home expands from 100 to 150 days a year.

■ Medicare beneficiaries begin paying extra \$4 monthly for catastrophic coverage; amount rises yearly but not expected to exceed \$10.20 by 1993.

Those enrollees who owe taxes will be assessed a 15 percent surtax, up to a maximum of \$800, on each \$150 of federal tax liability for 1989, payable in 1990. Surtax increases annually to 28 percent in 1993, with ceiling of \$1,050.

■ Medicaid starts paying Medicare deductibles, premiums, and coinsurance for those with incomes up to 85 percent of federal poverty level, gradually rising to 100 percent in 1992.

September 30, 1989

■ Spouses of Medicaid nursing home residents may now keep \$786 in monthly income and \$12,000 or half the couple's assets, whichever is greater. Monthly income allowance increases yearly until it reaches about \$950 a month in 1992.

January 1, 1990

■ The maximum a person would have to pay out of pocket for Part B physician services becomes \$1,370 a year.

■ Annual coverage for home health services increases

from 15 days to 38 days. Also, Medicare pays for health aides to provide up to 80 hours of respite care for relatives attending to patients at home.

January 1, 1991

■ Medicare starts paying 50 percent of outpatient prescription drug expenses exceeding \$600 a year. This share increases to 60 percent in 1992, 80 percent in 1993.

EDITOR'S COMMENT

The Right Question

We should be pleased that a legislator, particularly one as eminent as Chuck Hardwick, has focused on the "right question," a question that has not been given enough attention by others, including most of us in medicine (page 1035). Why should other groups, like the tobacco industry and Chrysler Corporation, be entitled to kudos for economic growth and to governmental subsidies when our health care system, the best in the world and one that has had the fat wrung out of it, continues to suffer from increasing governmental regulation and opprobrium? A sneaking suspicion is that the pursuit of pleasure is more rewarding than the rendering of service. (Howard D. Slobodien, M.D., Editor-in-Chief, *NEW JERSEY MEDICINE*)

FINI

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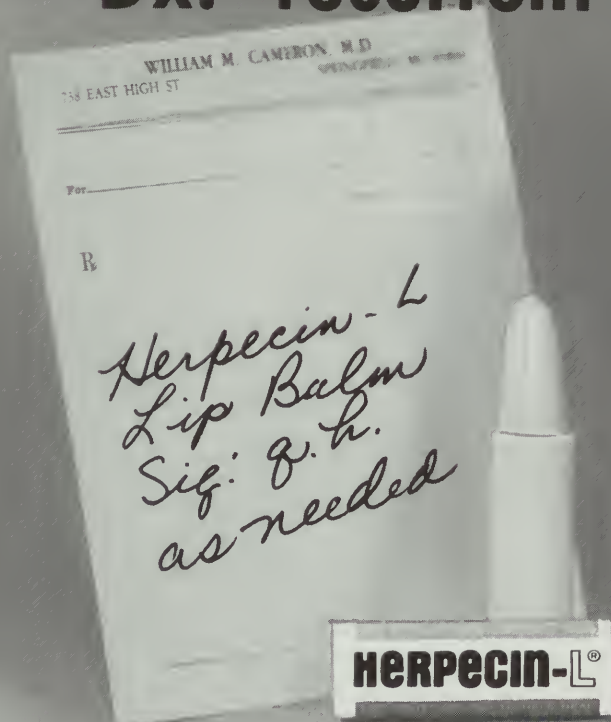
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CLARK MARTIN*

Forced Medicare Bill Stays Put; Malpractice Surcharge: To the Courts?

FORCED MEDICARE BILL STAYS PUT

Big victories can come in small packages. That's the case with the Society's latest triumph over A-2305, the forced Medicare bill.

After an Assembly debate which lasted fewer than five minutes—too short to be reported in the newspapers—Assemblyman Alan Karcher failed in his October 27 attempt to relieve the Health Committee of A-2305. Had the effort succeeded, the bill would be in position for a floor vote.

Intensive grassroots lobbying and face-to-face contacts with legislators in Trenton produced results. The brevity of the debate reflected that Mr. Karcher had fallen short of the 41 votes he needed to pry the bill out of committee.

The Assembly action consisted of Mr. Karcher's moving to relieve the Committee, followed by a rebuttal from Committee Chairman Harold Colburn. Majority Leader Chuck Haytaian then moved to table Karcher's motion—a parliamentary procedure which shuts off debate and requires an immediate vote.

The motion to table carried by a vote of 40 "yes," 26 "no," and 12 abstentions. A number of the 26 assemblymen who voted against tabling had told us privately that they will oppose forced Medicare if the bill itself is ever brought to a floor vote.

Assemblyman Karcher set the stage for our battle against A-2305 in a Trenton press conference a week prior to the October 27 debate.

Speaking to some 150 senior citizens at the conference, Mr. Karcher, who has announced that he will run for governor next year, said, "While Medicare is designed to remove a tremendous health care cost shouldered by the elderly, recipients still have to pay billions of dollars every year to physicians who charge

over and above Medicare assignment. It's time for this overcharging to cease."

Saying that his bill has been "languishing" in the Health Committee ever since it was introduced last January, Mr. Karcher told the seniors, "We have the power together to do this. Find out who represents you and call them on the phone and tell them how you feel."

"The health care cost system has been permeated by gross inequities. While senior citizens' income has remained at levels ranging from \$6,000 to \$11,000 per year, medical costs have been rising at two to three times the rate of general inflation. This bill would ensure that the elderly who need care will be able to afford it through the Medicare system. Delay of legislative action is inexcusable."

The press conference was organized by United Senior Action, an East Windsor-based umbrella organization which draws support from a number of labor unions and senior groups throughout the state.

The coalition's president, Joe Riordan, issued an inflammatory press release which railed against "the raw display of political muscle of the medical profession when they (sic) announced that they raised \$196,000 to kill this bill and to move against Assemblyman Karcher when he runs for reelection." (Mr. Riordan's reference is to medicine's political contributions in the 1987 legislative elections. Support was given to Democrats and Republicans in both houses, and never was directed against Assemblyman Karcher.)

"There are times when one has to wonder if some doctors ever had parents," said Riordan.

United Senior Action said it would present Governor Kean and legislative leaders with petitions signed by 10,000 seniors supporting forced Medicare. The coalition also announced plans for a future mass demonstration in support of the bill.

The coalition claims that the forced Medicare law has not hurt physicians in Massachusetts. As proof, it says that the number of physicians practicing there has increased from 16,550 in 1984 to 22,250 today.

(The Massachusetts Medical Society (MMS), however, points out that the current number of licenses does not take into account physicians who are inactive, retired, deceased, or practicing in other states. MMS says that only about 70 percent of the licenses are held by physicians actively practicing in the state.)

Despite the outcome of the Assembly debate, forced Medicare obviously will remain a volatile issue. With that in mind, it is important for physicians throughout the state to know where their assemblymen stand on A-2305.

Following is a breakdown of the vote on the "motion to table." When the vote was recorded, 2 of the 40 legislators who voted "yes" had changed to abstentions. For our purposes, an abstention is as good as a "yes." Bear in mind that not all 26 of the assemblymen who voted against the motion are supporters of A-2305.

Yes: Albohn (R-Whippany), Bennett (R-Freehold), Colburn (R-Mount Holly), Collins (R-Woodstown), Cooper (R-Atlantic City), Crecco (R-Bloomfield), Farragher (R-Freehold), Felice (R-Fair Lawn), Franks (R-Providence), Frelinghuysen (R-Morristown), Genova

*Mr. Martin is MSNJ's legislative consultant.

(R-Cranford), Hardwick (R-Westfield), Haytaian (R-Hackettstown), Hendrickson (R-Manahawkin), Kamin (R-Flanders), Kavanaugh (R-Somerville), Kelly (R-Montclair), Kline (R-Atlantic City), Kyrillos (R-Middletown), Littell (R-Franklin), Loveys (R-Parsippany), Martin (R-Parsippany), Miller (R-Totowa), Moran (R-Forked River), Ogden (R-Millburn), Palaia (R-Deal), Penn (R-Somerville), Randall (R-Westwood), Rocco (R-Cherry Hill), Roma (R-Paramus), Rooney (R-Emerson), Schluter (R-Flemington), Schuber (R-Ridgefield Park), Shinn (R-Mount Holly), Shusted (R-Westmont), J. Smith (R-Matawan), Stuhltrager (R-Woodbury), and Zecker (R-Little Falls).

No: Baer (D-Englewood), Brown (D-Newark), Bryant (D-Camden), Bush (D-East Orange), Charles (D-Jersey City), Doria (D-Bayonne), Doyle (D-Toms River), Duch (D-Garfield), Gill (D-Passaic), Girgenti (D-Paterson), Imprevuto (D-Secaucus), Karcher (D-Sayreville), Kenny (D-Hoboken), Kronick (D-North Bergen), Marsella (D-Sewell), Mattison (D-Newark), Mazur (D-Fort Lee), Menendez (D-Union City), Pascrell (D-Paterson), Pelly (D-North Brunswick), Riley (D-Blackwood), Roberts (D-Bellmawr), Schwartz (D-New Brunswick), R. Smith (D-Piscataway), Spadaro (D-East Brunswick), and Villapiano (D-Long Branch).

Abstentions: Aduato (D-Newark), Cimino (D-Hamilton Township), Deverin (D-Elizabeth), Foy (D-Mount Holly), Hudak (D-Elizabeth), Kalik (D-Edgewater Park), Kern (R-Ridgewood), LoBiondo (R-Cape May), McEnroe (D-South Orange), Otlowski (D-Perth Amboy), Patero (D-Manville), Salmon (D-Ocean City), Singer (R-Toms River), and Zangari (D-Irvington).

Absent: Naples (D-Trenton), and Watson (D-Trenton).

MALPRACTICE SURCHARGE: TO THE COURTS?

If the Society's campaign against the Insurance Department's proposed surcharge on malpractice premiums ends up in the courts, its cause will be well-served by testimony presented at an October 24 hearing in Trenton.

Some 150 physicians from across the state crowded an Insurance Department hearing room in an impressive display of opposition to the 5 percent annual surcharge proposed by the Department to make good a \$60 million debt run up by the Medical Malpractice Reinsurance Association. The Association, established by the state in 1976, sold underpriced malpractice insurance to 3,300 physicians and 450 podiatrists for six years.

Although the Association acted when it realized its rates were unsound in 1977, the requested 41.4 percent rate hike was rejected by then-Commissioner James Sheeran.

The Association, deactivated in 1982, currently holds \$22 million in reserves, but faces an estimated

\$82 million in claims over the next decade. The proposed surcharge would raise about \$9.15 million a year.

Testimony at the hearing focused on two issues: Is the surcharge legal, and is it fair?

On the question of legality, Hearing Officer Holly Bakke admitted that the law which created the Medical Malpractice Reinsurance Association is "extraordinarily vague" about whom should be surcharged to make up a deficit.

The law authorizes the insurance commissioner to "establish reasonable provisions through additional premium charges" in order to provide "an amount sufficient to meet the requirements of this act."

But the law also says the Association is to recoup its losses "through surcharges on *insureds*" (emphasis added).

Physicians who testified at the hearing—many of them directors of the Medical Inter-Insurance Exchange of New Jersey—reviewed the legislative history of the malpractice reinsurance law, pointed out that the Association was supposed to be activated only if malpractice insurance was not "readily available," underscored the Department's rejection of the requested rate hike, and spoke from the heart about the unfairness of surcharging physicians who did not purchase the Association's "bargain" insurance.

Said Society President Palma E. Formica, M.D., "The commissioner of insurance, representing the very agency that charged less and lost more, now is suggesting that physicians who were prudent and diligent in seeking a sound insurance vehicle should pay to vindicate those that took the easy way, at the request and urging of the state.

"Surely it is also unfair to ask doctors who were not even present in the state when these losses were incurred, or in practice at that time, to pay this debt. It is unfair to require the physicians not yet licensed to pay this debt. It is irresponsible to permit those that received the benefit which caused the loss to avoid the responsibility."

No organization testified in favor of the surcharge at the public hearing, but the American Insurance Association (AIA) submitted a supportive statement for the record. Possibly because the hearing record was so heavily weighted with the physician's viewpoint, the Insurance Department subsequently took an extraordinary step: it extended for one month the time for written comments to be submitted.

The AIA statement reads, in part, "The commissioner has developed a regulation that assesses insurance on the broadest possible basis, i.e. all physicians. The basis for this assessment is consistent not only with the legislation, but with the basic principle of insurance, i.e. that a risk be spread among the largest number of people."

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Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

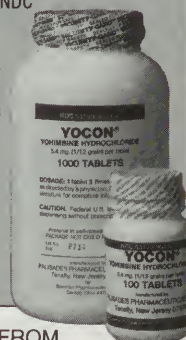
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical Letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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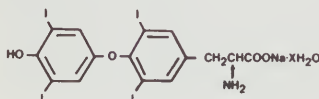
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FOR ORAL ADMINISTRATION

DESCRIPTION:

Each LEVOXINE (Levothyroxine Sodium, USP) tablet contains synthetic crystalline levothyroxine sodium (L-thyroxine). L-thyroxine is the principal hormone secreted by the normal thyroid gland. Chemically, L-thyroxine is designated as L-tyrosine, O-(4-hydroxy-3, 5-diiodophenyl) - 3,5-diiodo-... monosodium salt, hydrate. The molecular formula is $C_{15}H_{10}I_4NNa$ and the structural formula is:



CLINICAL PHARMACOLOGY:

The principal effect of thyroid hormones is to increase the metabolic rate of body tissues.

The thyroid hormones are also concerned with growth and development of tissues in the young.

The major thyroid hormones are L-thyroxine (T_4) and L-triiodothyronine (T_3). The amounts of T_4 and T_3 released from the normally functioning thyroid gland are regulated by the amount of thyrotropin (TSH) secreted from the anterior pituitary gland. T_4 is the major component of normal thyroid gland excretions and is therefore the primary determinant of normal thyroid functions. T_4 acts as a substrate for physiologic deiodination to T_3 in the peripheral tissues. The physiologic effects of thyroid hormones are mediated at the cellular level primarily by T_3 .

LEVOXINE (L-thyroxine) tablets taken orally provide T_4 which upon absorption can not be distinguished from T_4 that is secreted endogenously.

INDICATIONS AND USAGE:

LEVOXINE (L-thyroxine) tablets are indicated as replacement or supplemental therapy for diminished or absent thyroid function (e.g., cretinism, myxedema, nontoxic goiter or hypothyroidism generally, including the hypothyroid state in children, in pregnancy and in the elderly) resulting from functional deficiency, primary atrophy, from partial or complete absence of the gland or from the effects of surgery, radiation or antithyroid agents. Therapy must be maintained continuously to control the symptoms of hypothyroidism.

CONTRAINDICATIONS:

L-thyroxine therapy is contraindicated in thyrotoxicosis, acute myocardial infarction and uncorrected adrenal insufficiency.

WARNINGS:

Drugs with thyroid hormone activity, alone or together with other therapeutic agents, have been used for the treatment of obesity. In euthyroid patients, doses within the range of daily hormonal requirements are ineffective for weight reduction. Larger doses may produce serious or even life-threatening manifestations of toxicity, particularly when given in association with sympathomimetic amines such as those used for the anorectic effects.

PRECAUTIONS:

General — Caution must be exercised in the administration of this drug to patients with cardiovascular disease. Development of chest pains or other aggravation of the cardiovascular disease requires a reduction of dosage.

Information For The Patient — Patients on thyroid preparations and parents of children on thyroid therapy should be informed that:

1. Replacement therapy is to be taken essentially for life, with the exception of cases of transient hypothyroidism, usually associated with thyroiditis, and in those patients receiving a therapeutic trial of the drug.
2. They should immediately report during the course of therapy any signs or symptoms of thyroid hormone toxicity, e.g., chest pain, increased pulse rate, palpitations, excessive sweating, heat intolerance, nervousness, or any other unusual event.
3. In case of concomitant diabetes mellitus, the daily dosage of antidiabetic medication may need readjustment as thyroid hormone replacement is achieved. If thyroid medication is stopped, a downward readjustment of the dosage of insulin or oral hypoglycemic agent may be necessary to avoid hypoglycemia. At all times, close monitoring of urinary glucose levels is mandatory in such patients.
4. In case of concomitant oral anticoagulant therapy, the prothrombin time should be measured frequently to determine if the dosage of oral anticoagulants is to be readjusted.
5. Partial loss of hair may be experienced by children in the first few months of thyroid therapy, but this is usually a transient phenomenon and later recovery is usually the rule.

Laboratory Tests — The patient's response to thyroid replacement may be followed by laboratory tests such as serum thyroxine (T_4), serum triiodothyronine (T_3), free thyroxine index and thyroid stimulating hormone (TSH) blood levels.

Drug Interactions — In patients with diabetes mellitus, addition of thyroid hormone therapy may cause an increase in the required dosage of insulin or oral hypoglycemic agents. Therefore, patients with diabetes mellitus should be observed closely for possible changes in antidiabetic drug dosage requirements.

Patients stabilized on oral anticoagulants who are found to require thyroid replacement therapy should be watched very closely when therapy is started. If a patient is truly hypothyroid, it is likely that a reduction in anticoagulant dosage will be required. No special precautions appear to be necessary when oral anticoagulant therapy is begun in a patient already stabilized on maintenance thyroid replacement therapy.

Cholestyramine binds both T_4 and T_3 in the intestine, thus impairing absorption of these thyroid hormones. In vitro studies indicate that the binding is not easily removed. Therefore, four to five hours should elapse between administration of cholestyramine and thyroid hormones.

Estrogens tend to increase serum thyroxine-binding globulin (TBG). In a patient with a non-functioning thyroid gland who is receiving thyroid replacement therapy, free thyroxine may be decreased when estrogens are started thus increasing thyroid requirements. However, if the patient's thyroid gland has sufficient function the decreased free thyroxine will result in a compensatory increase in thyroxine output by the thyroid. Therefore, patients without a functioning thyroid gland who are on thyroid replacement therapy may need to increase their thyroid dose if estrogens or estrogen containing oral contraceptives are given.

Drug/Laboratory Test Interactions — The following drugs or moieties are known to interfere with laboratory tests performed on patients taking thyroid hormone: androgens, corticosteroids, estrogens, oral contraceptives containing estrogens, iodine-containing preparations, and the numerous preparations containing salicylates.

1. Changes in TBG concentration should be taken into consideration in the interpretation of T_4 and T_3 values. In such cases, the unbound (free) hormone should be measured. Pregnancy, estrogens, and estrogen-containing oral contraceptives increase TBG concentrations. TBG may also be increased during infectious hepatitis. Decreases in TBG concentrations are observed in nephrosis, acromegaly, and after androgen or corticosteroid therapy. Familial hyper- or hypo-thyroxine-binding-globulinemias have been described. The incidence of TBG deficiency approximates 1 in 9000. The binding of thyroxine by thyroid-binding prealbumin (TBPA) is inhibited by salicylates.
2. Medical or dietary iodine interferes with all in vivo tests of radio-iodine uptake, producing low uptakes which may not be reflective of a true decrease in hormone synthesis.
3. The persistence of clinical and laboratory evidence of hypothyroidism in spite of adequate dosage replacement indicates either poor patient compliance, poor absorption, excessive fecal loss, or inactivity of the preparation. Intracellular resistance to thyroid hormone is quite rare.

Carcinogenesis, Mutagenesis, And Impairment

Of Fertility — A reportedly apparent association between prolonged thyroid therapy and breast cancer has not been confirmed and patients on thyroid for established indications should not discontinue therapy. No confirmatory long-term studies in animals have been performed to evaluate carcinogenic potential, mutagenicity, or impairment of fertility in either males or females.

Pregnancy — Category A — Thyroid hormones do not readily cross the placental barrier. The clinical experience to date does not indicate any adverse effect on fetuses when thyroid hormones are administered to pregnant women. On the basis of current knowledge, thyroid replacement therapy to hypothyroid women should not be discontinued during pregnancy.

Nursing Mothers — Minimal amounts of thyroid hormones are excreted in human milk. Thyroid is not associated with serious adverse reactions and does not have a known tumorigenic potential. However, caution should be exercised when thyroid is administered to a nursing woman.

Pediatric Use — Pregnant mothers provide little or no thyroid hormone to the fetus. The incidence of congenital hypothyroidism is relatively high (1:4,000) and the hypothyroid fetus would not derive any benefit from the small amounts of hormone crossing the placental barrier. Routine determinations of serum (T_4) and/or TSH is strongly advised in neonates in view of the deleterious effects of thyroid deficiency on growth and development.

Treatment should be initiated immediately upon diagnosis, and maintained for life, unless transient hypothyroidism is suspected; in which case, therapy may be interrupted for 2 to 8 weeks after the age of 3 years to reassess the condition. Cessation of therapy is justified in patients who have maintained a normal TSH during those 2 to 8 weeks.

ADVERSE REACTIONS:

Adverse reactions are due to overdosage and are those of induced hyperthyroidism.

OVERDOSAGE — Excessive dosage of thyroid medication may result in symptoms of hyperthyroidism. Since, however, the effects do not appear at once, the symptoms may not appear for one to three weeks after the dosage regimen is begun. The most common signs and symptoms of overdosage are weight loss, palpitation, nervousness, diarrhea or abdominal cramps, sweating, tachycardia, cardiac arrhythmias, angina pectoris, tremors, headache, insomnia, intolerance to heat and fever. If symptoms of overdosage appear, discontinue medication for several days and reinstitute treatment at a lower dosage level.

Laboratory tests such as serum T_4 , serum T_3 and the free thyroxine index will be elevated during the period of overdosage.

Complications as a result of the induced hypermetabolic state may include cardiac failure and death due to arrhythmia or failure.

TREATMENT OF OVERDOSAGE — Dosage should be reduced or therapy temporarily discontinued if signs and symptoms of overdosage appear. Treatment may be reinstituted at a lower dosage. In normal individuals, normal hypothalamic-pituitary-thyroid axis function is restored in 6 to 8 weeks after thyroid suppression.

Treatment of acute massive thyroid hormone overdosage is aimed at reducing gastrointestinal absorption of the drugs and counteracting central and peripheral effects, mainly those of increased sympathetic activity. Vomiting may be induced initially to further gastrointestinal absorption can reasonably be prevented and barring contraindications such as coma, convulsions, or loss of the gagging reflex. Treatment is symptomatic and supportive. Oxygen may be administered and ventilation maintained. Cardiac glycosides may be indicated if congestive heart failure develops. Measures to control fever, hypoglycemia, or fluid loss should be instituted if needed. Antiadrenergic agents, particularly propranolol, have been used advantageously in the treatment of increased sympathetic activity. Propranolol may be administered intravenously at a dosage of 1 to 3 mg over a 10 minute period orally, 80 to 160 mg/day, especially when no contraindications exist for its use.

DOSAGE AND ADMINISTRATION:

The goal of therapy should be the restoration of euthyroidism as judged by clinical response and confirmed by appropriate laboratory tests such as serum thyroxine (T_4), serum triiodothyronine (T_3), free thyroxine index and thyroid stimulating hormone (TSH) blood levels. The age and general condition of the patient and the severity and duration of hypothyroid symptoms determine the starting dosage and the rate of incremental dosage increase leading to a final maintenance dosage.

In otherwise healthy adults, the recommended initial dose is 25 to 100 mcg (0.025 to 0.1 mg) daily, while the predicted full maintenance dose of 100 to 200 mcg (0.1 to 0.2 mg) daily may be achieved in two to three weeks.

In the elderly patient with long standing disease, evidence of myxedema, or evidence of cardiovascular dysfunction, the initial dose may be as little as 12½ mcg (0.0125 mg) per day. Incremental increases of 25 mcg (0.025 mg) per day at 3 to 4 week intervals may be instituted depending on patient response. It is the physician's judgement of the severity of the disease and close observation of patient response which determine the rate and extent of dosage increase.

In infants and children there is a great urgency to achieve full thyroid replacement because of the critical importance of thyroid hormone in sustaining growth and maturation. Despite the smaller body size, the dosage needed to sustain a full rate of growth, development and general thriving is higher in the child than in the adult. The recommended daily replacement dosage of L-thyroxine in childhood is: 0-1 years: 5-6 mcg/kg; 1-5 years: 3-5 mcg/kg; 6-12 years: 4-5 mcg/kg of body weight daily.

DOSAGE FORMS AVAILABLE:

LEVOXINE (L-thyroxine) tablets are supplied as oval, color-coded, potency marked tablets in eleven strengths: 12½ mcg (0.0125 mg)—maroon, 25 mcg (0.025 mg)—orange, 50 mcg (0.05 mg)—white, 75 mcg (0.075 mg)—purple, 100 mcg (0.1 mg)—yellow, 112 mcg (0.112 mg)—rose, 125 mcg (0.125 mg)—brown, 150 mcg (0.15 mg)—blue, 175 mcg (0.175 mg)—turquoise, 200 mcg (0.2 mg)—pink and 300 mcg (0.3 mg)—green, in bottles of 100, 1000, unit dose cartons of 100 (10 strips of 10 each), and 500 mcg injectable (See injectable package insert).



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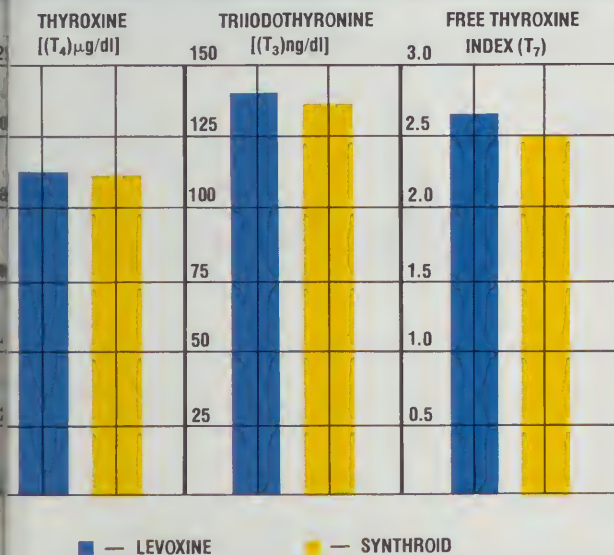
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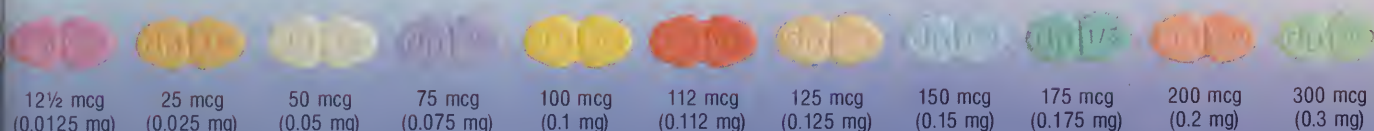
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Reducing Malpractice Claims

Vacation Coverage Tips; Physician Insurers Float New Proposal for Fault-Based Alternative System

VACATION COVERAGE TIPS

Pre-vacation arrangements for practice coverage are vital to assure trouble-free continuation of optimal medical care to your patients in your absence. Coverage plans that are complete and well thought out, coupled with good communication with the covering physician and your patients, will help to guarantee that your patients' needs are being met adequately.

In selecting a physician to cover your practice, try to find a physician in your specialty whose treatment philosophies are compatible with your own. A longtime patient will be comfortable with your methods and treatment style, and any radical departure or change from this by a covering physician may be met with resistance and noncompliance on the part of your patient. It is important that the physician covering your practice is aware of all aspects of coverage prior to your departure—your expectations, your needs and those of your patients, "on-call" duties, emergency coverage, answering service information, and in-hospital patient requirements. Additionally, confirm that the physician providing your vacation coverage has professional liability insurance applicable to this locum tenens activity.

In its routine review of cases, the Pennsylvania Medical Society Liability Insurance Company's Claims Committee continues to see problems develop because of flaws in a physician's vacation coverage, especially with regard to in-hospital practice. It often is wise to postpone elective surgical procedures until your return, rather than have a covering physician be required to step in during the immediate postoperative period. Inform the patient of your vacation plans so

that he knows you will not be available for the entire postoperative course before his decision regarding the date of elective surgery. If you have surgical patients in the hospital at the time you begin your leave, relaying information on the care of these patients especially is important. Make sure your covering physician is aware of postoperative patients' needs with regard to dressings, drains, physical therapy, suture removal, and allergies.

If you receive a consult request prior to your departure, make sure someone will followup in your absence, especially on surgical consults. The Pennsylvania Medical Society Liability Insurance Company has seen malpractice cases arise out of communication breakdowns in the consultation process. For example: you are called in as a surgical consultant on a patient in acute abdominal pain; you decide that the patient is not a candidate for surgery at that time; note your findings and impressions to that effect in the patient's chart; and then leave for vacation. Prior to leaving, you, as the consultant, have to be sure that the attending physician who requested the consult is aware of its results, is aware that you are going on vacation, and is aware of the physician covering the practice in your absence. Additionally, it is important that the covering physician is aware of the consult and can followup should the patient's condition worsen or require re-evaluation. Effective communication between all parties involved is essential to the success of any consultation.

Give your patients advance notice of your plans to be away and let them know who will be taking care of them in your absence. When possible, introduce your replacement to them and express your confidence in his competence and ability to meet their medical needs while you are away.

Make sure your answering service received complete instructions regarding your absence and your coverage arrangements. Patients who call should be informed of your absence, who is covering your practice, and how to reach your replacement easily. Having the answering service keep a written log of all patient calls may be helpful to you for postvacation followup.

On your return, get a complete report from the covering physician regarding what transpired with your practice and your patients while you were away. Additionally, try to get feedback from your patients regarding their experiences with your replacement. If there were any problems or patient dissatisfaction, these should be discussed with the patients and the covering physician immediately to help your next absence go more smoothly.

Taking the time to work out practice coverage details before you leave will help make your vacation less traumatic for all concerned—you, your patients, your covering physician, your colleagues, and your staff—and will help ensure the continued delivery of optimal patient care. (Pennsylvania Medical Society Liability Insurance Company, *Patient Rx Newsletter*, Volume 10, No. 4, July 1988.)

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are Director of the Department and Director of Special Projects.

PHYSICIAN INSURERS FLOAT NEW PROPOSAL FOR FAULT-BASED ALTERNATIVE SYSTEM

The conceptual framework for a new plan for resolving medical malpractice claims was unveiled at the annual meeting of the Physician Insurers Association of America (PIAA) in San Diego. The proposal, which a committee of PIAA is refining, combines a fault-based administrative system for determining fault with a fixed schedule of benefits.

Modeled in some respects after workers' compensation programs, the plan envisioned would offer incentives to encourage plaintiffs to resolve claims through an optional administrative system rather than the courts. A three-person commission, composed of a judge, physician, and layperson, would be appointed by a state's governor to handle determinations of fault. The commission would have rule-making power and would function much as do screening panels already operating in a number of states.

All medical costs, including rehabilitation and rehabilitation services, would be paid without limitation. Wage losses would be computed as a function of the plaintiff's actual wage loss, but with a cap based on some multiple of the average weekly wage in the state. All these costs would be paid as incurred, and all would be subject to a collateral source offset.

All awards for noneconomic damages would be paid according to a fixed schedule of benefits, again following the workers' compensation model.

There would be a set base amount for permanent total disability, from which payments for other injuries and losses would be calculated on a percentage basis.

Although the plan would impose some restrictions on attorneys' contingency fees, it also would provide for part payment to attorneys who use the administrative system even when a case is lost.

A PIAA legal counsel said one of four basic principles that the association's committee to study alternatives to the present system wanted to incorporate in any proposal was that attorneys' fees bear a closer relationship to the actual work involved on a case.

"Attorneys should be primarily paid on the basis of their time," the PIAA attorney said. "However, as an incentive for selection of the administrative system for determining liability, we would propose that at least for those who select the system, that attorneys' fees be paid over and above the other elements of loss."

"Most controversial is our proposal that if cases with some reasonable basis come through the administrative system and are lost, that some portion of attorney's fees be paid. Attorneys might be paid one-third of their reasonable number of hours in these cases," the PIAA attorney said.

This provision counters arguments for the contingency fee system from plaintiffs' attorneys who say they take many cases for which they are paid nothing.

"We also believe some element for pain and suffering should be included in the plan," the PIAA attorney said. "We did not feel it was politically feasible, and perhaps neither constitutional nor fair, to eliminate such payments entirely."

The purpose of a fixed benefit schedule was to design a system providing for "fair, quick, uniform com-

pensation," the PIAA attorney said. "Certainly there should be some savings, but not necessarily drastically reduced awards across the board. The principal goal is to establish some uniformity in the process of resolving claims and get a handle on the trend for future cost increases."

Comparisons of the PIAA proposal now being developed with the alternative system introduced by the American Medical Association and 32 national medical specialty societies last January were inevitable during the session at which the work of the PIAA Alternatives Committee was reported. The AMA plan, which would move claims resolution out of the courts to an administrative body—either an existing, expanded state board of medical examiners or a separate entity—also calls for a tougher, escape-proof net for identifying, disciplining and/or sidelining negligent physicians.

The Committee chairman, legal counsel for Pennsylvania Medical Society Liability Insurance Company, praised the AMA plan as innovative and one that should operate faster and less expensively, and should bring some uniformity and predictability to the claims resolution process. She also commended the provisions calling for risk management and quality assurance as "novel" and appropriate.

The PIAA Alternatives Committee did express concerns about some provisions in the AMA plan. Said the chairman, "The various levels of appeal associated with the step-by-step process could cause it to bog down. However, the dual function—performance of both disciplinary and claims resolution by a single entity—is most troubling in many ways."

Program costs eventually could be passed along to medical malpractice insurers and health care providers, "making it very expensive to a small group of people," the chairman said.

The senior attorney in the AMA Office of the General Counsel and coordinator of the special task force on professional liability and insurance, said that AMA's program offer states two options: creation of a separate administrative agency or expansion of the existing medical licensing board to handle claims.

"Virtually every state I have talked to is interested in establishing a separate agency," the attorney said. "The dual function may appeal to some medical boards, but it certainly does not appeal to many medical societies."

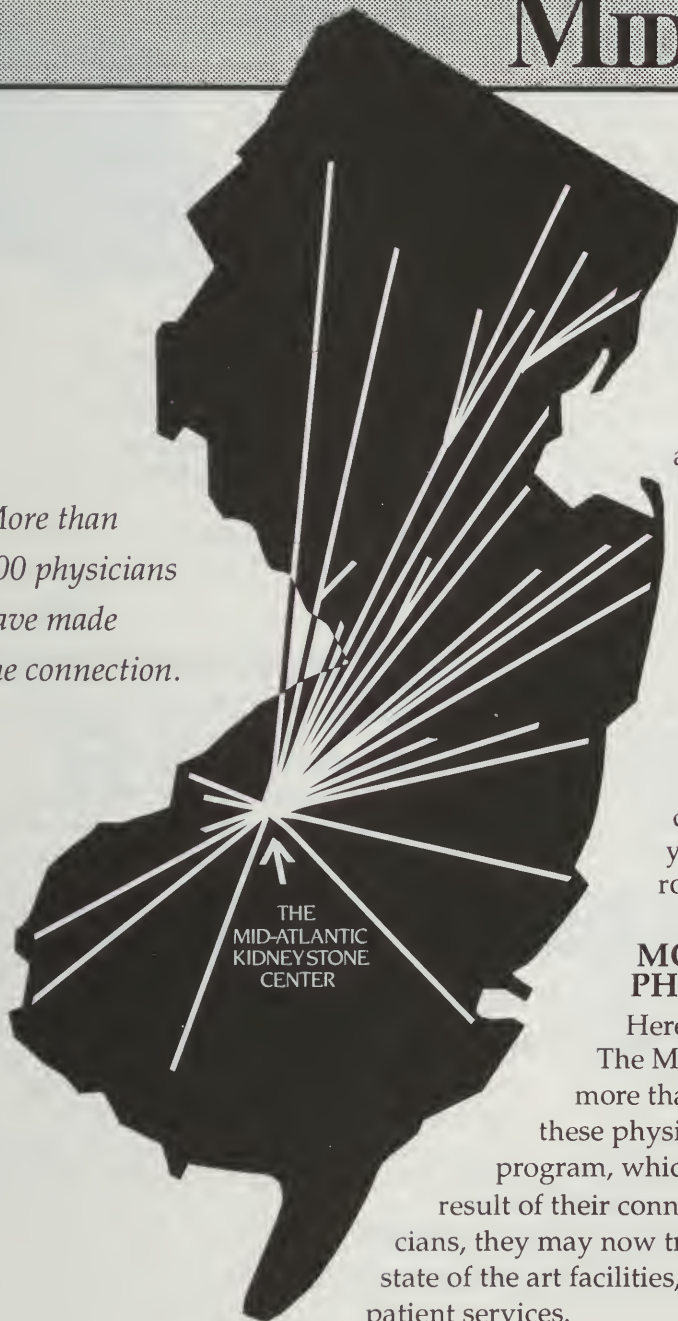
The attorney said that the AMA/specialty society program continues to be refined. Several states are considering taking the proposal to their legislatures, Utah in particular.

The chairman of the committee to study alternatives said it is encouraging that several different solutions are being proposed and may be tested. The PIAA legal counsel noted the AMA and PIAA's proposals were similar in many respects and shared the same goals.

The PIAA proposal has not been formally endorsed by the alternatives committee or the organization's board. It should be finalized later in the year when the committee, chaired by Peter Sweetland, president, Medical Inter-Insurance Exchange of New Jersey, issues its final report. (*Medical Liability Monitor*, Vol. 13, Number 6, June 17, 1988)

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PALMA E. FORMICA, M.D.*

Happy holidays! In this season of giving and expressing wishes for good health, happiness, and

hope for the new year, I take this opportunity to thank you for the many gifts, as physicians, you give to the people of New Jersey.

To the thousands of you who serve the poor and the disadvantaged, a heartfelt thanks. Every time you see a Medicaid patient or accept assignment, you give a special gift of caring—of time and money. Government officials and some senior citizens forget that accepting assignment is a gift from each of you. What other segment of this nation gives so much, yet is acknowledged so little. Every time you treat a "service" patient in the hospital, you alone are uncompensated for the time, effort, and caring. Still, you do it because you are a physician.

How many hours have been given to hospital committees for peer review, quality assurance programs, educational seminars, and other committees to make the hospital environment a better place? Financial contributions for building projects and fundraising activities are supported by staff members. Does anyone remember to say "thank you"?

Your gift of friendship and support is most meaningful to our colleagues who are struggling with impairment. The first evidence of your love and concern comes by helping the afflicted physician face reality and by assisting in efforts for rehabilitation. Thank you for supporting the "Adopt a Family Program" which helps our own through bleak financial times. Each physician who has made it back to wellness is a testimony to each of you. I am overwhelmed by the generosity of service of the recovering. For this gift of love, I salute you.

Your efforts on behalf of clean air, safe shores and highways, toxic wastes, nuclear power hazards, and environmental protection predated the political bandwagon. Your actions and commitment for change led the way, even when the issues were not popular. We thank each of you for your advocacy for the health of the state.

Who led the way in the fight against AIDS in treatment and research? You, the doctors of this state responded with compassion and in a manner worthy of the highest ideals of the profession. For this gift, we thank you.

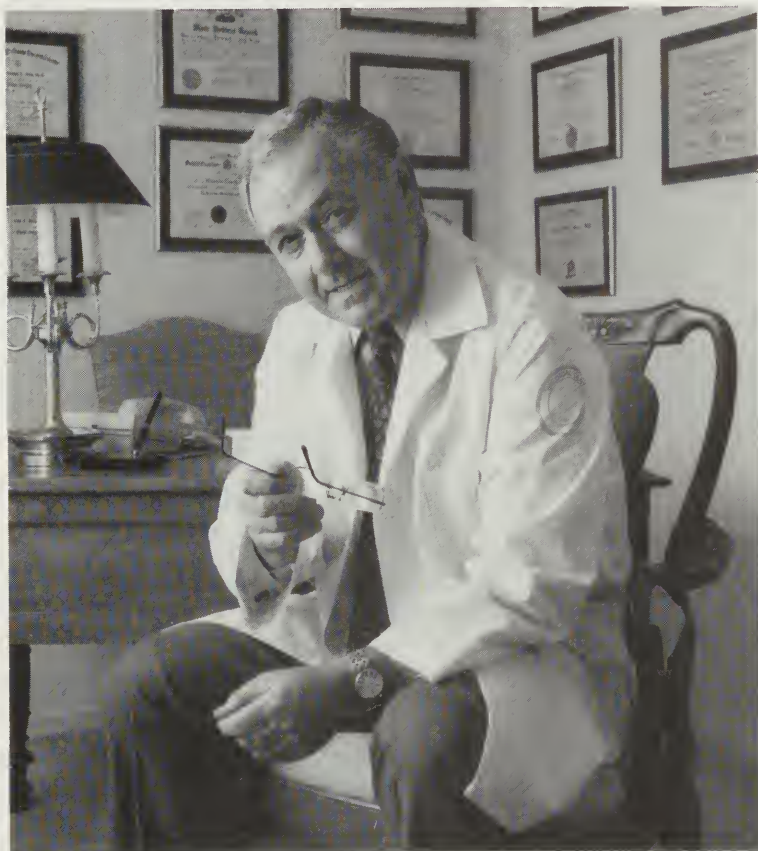
In hundreds of ways, doctors are involved in promoting cultural activities of the visual and performing arts as supporters and patrons. These, too, are gifts of service. What church, synagogue, or temple does not call upon the service and involvement of its physicians? The gifts physicians give are legion. We have all benefited from your involvement. You are the support and underpinning which makes our dedication meaningful and worthwhile.

For these many gifts, the Medical Society of New Jersey is grateful and proud. Giving is 365 days a year.

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*Correspondence may be addressed to Dr. Formica, President, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648.

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About Nurses and Nursing

HOWARD D. SLOBODIEN, M.D.*

The relationship between physicians and nurses in recent years has been far from ideal, despite the obvious need for the two professions to work as a team in the delivery of patient care.

Many reasons for this schism can be cited. Nurses have expressed resentment at the attitude of physicians toward them—as second class citizens in treating patients. They also have resented physician “interference” in the determination of the proper education needed to produce a fully qualified nurse, whether it should involve two, three, or four years of training.

On the other hand, physicians have expressed repeatedly the dicta, “If you want to be a physician, go to medical school. There can be only one captain of the ship.” We also have suggested that baccalaureate degreed nurses have shown a firm grasp of theory, but have not demonstrated equivalent clinical skills.

The present, and continuing, shortage of nurses has compounded the problem. As a partial answer, the AMA has proposed the establishment of a new category

of health care worker, the registered care technologist. What a furor this has raised! The registered nurse (RN) thinks it is inappropriate, unwise, and dangerous. The licensed nurse practitioner (LPN), faced with a trend by some hospitals toward all RN staffs, also considers it imprudent, but also worries even more about the job. Both of these groups also feel this type of practitioner would be performing nursing duties and that the training program should be run by nurses, not by physicians, although appropriate physician input would be welcomed.

Physicians in New Jersey probably have had a better relationship with nurses than have those in other states. New Jersey has been the only state not to license physician assistants (PAs) and physicians have been joined by nurses in maintaining opposition to the PA. Perhaps this common effort can continue as we try to insure proper care for our patients.

The Medical Society of New Jersey Task Force on the Shortage of Nurses and Technical Personnel is wrestling with the problem. It has recommended that the AMA's registered care technologist proposal not be implemented in New Jersey; the MSNJ Board of Trustees agrees. The Task Force also has considered most carefully a proposal by the University of Medicine and Dentistry of New Jersey to establish a certificate program for ancillary nursing personnel, to be implemented by the Department of Nursing Education. This proposal has received approval. And the Task Force will continue to explore these and other important matters, such as scholarships for nurses and nurse-physician interpersonal relationships. We should applaud and encourage this effort.

It would be worthwhile for us to reflect on the medical aspects of nursing care. And vice versa. Even if we were to eliminate the coronary care nurse, the intensive care nurse, the nurse-midwife, the nurse-anesthetist, and others in special-care situations from consideration, the average good “floor nurse” must practice medicine in order to be effective. After all, we expect “appropriate” calls about our hospitalized patients at 2:00 A.M.; the difference between being appropriate or inappropriate certainly involves the exercising of medical judgment. Finally, we should remember why the patient is in the hospital. We may leave the orders, but the patient is there for nursing care. Same-day surgery may have removed many individuals from hospital beds, but the ones who remain require even more dedicated care by the nurses. Let us work together.

*Correspondence may be addressed to Dr. Slobodien, editor-in-chief, *NEW JERSEY MEDICINE*, Two Princess Road, Lawrenceville, NJ 08648.

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Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

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- Discontinue Cecilor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Cecilor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in

moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.

- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Cecilor penetrates mother's milk. Exercise caution in prescribing for these patients.

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Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Cecilor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia.

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- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
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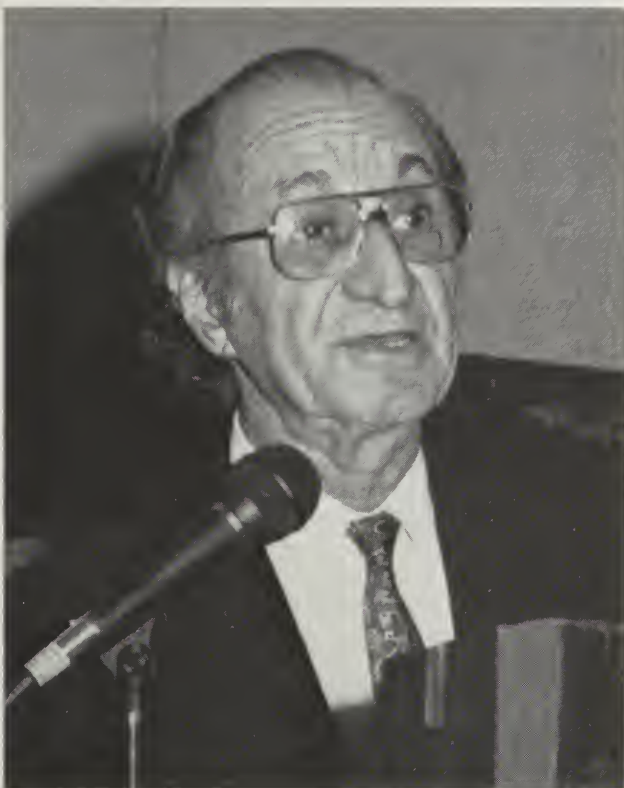
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Bayonne Pediatrician Honored

Dr. Harold Perkel, a member of our Hudson County component, was honored as Health Care Professional of the Year.

A Bayonne physician whose 40-year practice has focused on patients with developmental disabilities was honored by the Association for Retarded Citizens/New Jersey (ARC/NJ).



Dr. Harold Perkel

Harold Perkel, M.D., received the Association's first Health Care Professional of the Year award at ARC's annual convention. Dr. Perkel began his clinical practice in pediatrics in Bayonne in 1949, the same year that the ARC incorporated in New Jersey.

The award, initiated by the Association through its special project, Mainstreaming Medical Care for Community Residents, is designed to offer recognition to those medical or dental professionals with exceptional records of providing health or dental care services for people with developmental disabilities and/or mental retardation.

Dr. Perkel has been serving the handicapped population for many years and has contributed to expanding access to primary medical care for people with developmental disabilities.

A respected lecturer on developmental disabilities, Dr. Perkel founded (in 1968) and served as its medical director until 1981 the Hudson Pre-School Class for Children with Learning Disabilities.

He was school physician in the Bayonne public school district from 1974 to 1983, where he served as coordinator of a screening program he established for all kindergarten and first-grade children for the early identification of children with learning disabilities.

Dr. Perkel was founder, coordinator, and still is medical director of the state and county funded specialized program for developmentally disabled children at Jewish Hospital and Rehabilitation Center in Jersey City.

The distinctive award was presented to Dr. Perkel before 300 convention participants by Patricia O'Donnell, ARC/NJ regional vice-president and parent of a child with Down's syndrome. She said: "His medical credentials aside ... and they are prodigious ... Dr. Perkel receives this honor for more valuable reasons. He is a pediatrician of outstanding reputation and distinction because of his exceptional diagnostic skills and because of the deep sensitivity and understanding with which he treats his patients who have developmental disabilities and their families.

"Dr. Perkel often encourages parents to reach for the stars, even as he urges them to accept their child's limitations. He is a caring professional who sets a fine example for others to emulate in treating our special populations."

In accepting the new award, Dr. Perkel suggested how all of us, working with the handicapped, would best meet the challenges ahead of us. He said: "We must identify the developmentally disabled early on; better still, we must tackle the problem of prevention. We must work with a pregnant teenager toward the prevention of prematurity and low birth weight.

"We all must have compassion and empathy in every aspect of our involvement with the handicapped.

"We must all be advocates for the handicapped, working with them, their families, their educators, their medical and para-medical professionals, and the community around them.

"Perhaps the most handicapping aspect of any disability is not necessarily the cognitive problem, the hyperactivity, or the emotional coloring, but the reaction of society to the disability and the inability of society to accept the child or the adult with his or her handicap."

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COMMENTARY: THE CARDIAC REHABILITATION CENTER

THEODORE H. GOLDBERG, M.D., AND MARY DAMKEN, R.N., WESTWOOD*

Cardiac rehabilitation is an important part of the total management of the cardiac patient. A hospital-based program designed to meet that need is safe and effective, and an appropriate service for a community hospital.

The Cardiac Rehabilitation Center at Pascack Valley Hospital, Westwood, was initiated in 1978, offering exclusively a phase II monitored program. Since its inception, phases I and III also have been developed. The program now includes the three basic areas of rehabilitation: phase I—inpatient—early postmyocardial infarction; phase II—telemetry monitored exercise program; and phase III—supervised, nonmonitored exercise program.

Over 476 patients have been supervised through the program, averaging 90 percent male and 10 percent female; ages ranged from 35 to 73 years with an average of 56.5 years. Statistically, patients' medical diagnoses upon entering the Center were: 49 percent s/p myocardial infarction (MI); 31 percent s/p coronary artery bypass grafting (CABG); 2 percent s/p angioplasty; and 10 percent high-risk patients.

Pascack Valley Hospital is a nonprofit, voluntary hospital with a primary service area encompassing a suburban community of 250,000. The current bed capacity is 309, with 9 coronary care unit beds, a telemetry stepdown unit, and a medical intensive care unit. The hospital does not have a catheterization laboratory, and regularly transfers patients for coronary angiography, angioplasty, and coronary bypass surgery to a tertiary care center seven miles away. The patients return to the care of their own physicians following

interventional therapy. There is, therefore, a steady flow of patients needing cardiac rehabilitation services, including postinfarction patients, postbypass and angioplasty, as well as high-risk or symptomatic patients needing exercise in a supervised setting. It is of interest, that although patterns of coronary care have changed, with many more patients receiving aggressive interventional treatment, two aspects of cardiac care remain focused in the community hospital—early acute care and late rehabilitative care.

The cardiac rehabilitation program was established as a cooperative effort with Valley Hospital in Ridgewood. This hospital, approximately five miles away, serves a similar socioeconomic population. A joint committee of the hospitals was formed to avoid the unnecessary duplication of facilities, or staff in supervising the operation of the Center. Although the staff of Valley Hospital continues to send a moderate number of referrals, the bulk of the patients are referred by the staff of Pascack Valley Hospital.

PHASE II

The patient is referred to the phase II program by

*From Pascack Valley Hospital where Dr. Goldberg is director, Department of Cardiology, and Ms. Damken is director, Center for Health and Fitness. Correspondence may be addressed to Dr. Goldberg, Westwood Cardiology Associates, P.A., 336 Westwood Avenue, Westwood, NJ 07675.

his cardiologist, primary physician, or community hospital. A patient enters the program at two to four weeks' postevent or postsurgery. During the interim, a patient may have been advised to begin an at-home walking program. A patient who is exercised in the phase II program is a potentially unstable patient. Exercise sessions are supervised by an exercise physiologist with coronary care unit nursing background and advanced cardiac life support (ACLS) training. In order to minimize liability, maximize observation, and obviate the need for direct physician presence during the exercise sessions, it was felt that telemetry monitoring should be used.

The program begins with the initial interview and consultation with the patient by the medical director (a cardiologist), and by the exercise physiologist. Patient history, exercise stress test, and electrocardiogram are reviewed and an individual exercise prescription then is determined. Realistic goals are developed further regarding exercise accomplishments, and recommendations are offered to modify lifestyle behaviors of diet, medication, smoking, and stress management.

Patient progress is reviewed by the exercise physiologist and is discussed further with the medical director and primary physician as is appropriate.

Exercise training prescriptions are developed and based upon the exercise stress test utilizing the Bruce protocol. Target heart rates are developed and adjusted accordingly for medication, fitness level, medical history, and anginal threshold history. A patient is exercised at approximately 70 to 85 percent of his maximum heart rate as demonstrated on the graded exercise test. A patient is seen four times per week for 30 to 45 minute sessions over eight weeks to equal 32 sessions. A patient is monitored continuously by telemetry, and blood pressure checks are taken during warmup, peak exercise, and cool-down phases and a patient is encouraged to subsequently check pulse and to utilize the concept of perceived exertion to modify exercise intensities for any given day.

Exercise is carried out through the various equipment utilizing circuit training. A patient is advised to build up to one 15-minute endurance bout on one chosen piece of equipment consisting of four Monarch™ bicycle ergometers, one Quinton™ treadmill, one Monarch™ arm ergometer, and two Tunturi™ rowing machines. Intervals of 5 to 10 minutes then are utilized for the duration of the session on the other equipment. Participation of the patient with all pieces of equipment also is encouraged to foster a total body workout, as well as a cardiovascular workout. The introduction of light weights (one to ten pounds) takes place in the second half of the program. Weights are utilized to increase upper body range of motion and flexibility, as well as improve strength. Light weights are encouraged with high repetitions performed. The circuit of exercise includes bicep curl, tricep extension, lateral raise and shoulder press for the deltoid muscle, butterfly extension for the pectoralis major, French curl for the tricep, and upright rowing for the total shoulder girdle.

Near the completion of the program, a patient who is not found to be at risk for dysrhythmias is removed from the telemetry monitors and is supervised further through use of pulse checks and quick rhythm checks using paddles from the Life Pak emergency unit. Workload levels are increased progressively according to patient tolerance. Patient progress is reviewed by the exercise physiologist and is discussed further with the medical director and primary physician as is appropriate. Monthly progress reports are generated for the physician as well as the patient.

All sessions are conducted in a designed room: large windows provide copious sunlight, pastel colors create a calming influence, and location of mirrors is such that a patient receives positive reinforcement of his own exercise. In addition, the room has access to a television and video cassette recorder which offer the opportunity to view educational topics on all aspects of rehabilitation. Various topics are presented that are related to benefits of aerobic exercise, risk factors, cardiovascular disease, hypertension, stress management, smoking cessation, and nutrition.

The patient is encouraged to participate in nutritional counselling by a registered dietician at the hospital and to develop new and healthful ways to implement a healthy diet; the spouse is encouraged to attend these sessions. Dietary lipid profiles are taken at the beginning and end of the program.

PHASE III

Upon completion of the phase II program, the patient is advised to continue with the newly acquired exercise routines and to meet with the exercise physiologist to update progress and new goals. The patient who continues to be at a higher risk due to poor ventricular function, dysrhythmias, or poor functional capacities is encouraged to continue exercising under supervision at the Center with the phase III program. Very often a patient without any such factors also will choose the option of continuing at the Center. The patient who does not join the phase III program is encouraged to return occasionally for a reassessment of their home-exercise program.

The 12-week phase III program consists of three sessions per week to include 5 minutes of warmup exercises (stretching, flexibility, and range of motion), 30 to 40 minutes of aerobic activity, 5 minutes of hand weights, and 5 to 10 minutes of active cool-down. Exercise prescription again is based on the factors mentioned for a phase II patient. Telemetry monitors are removed and a patient independently checks pulses and perceived exertion levels. Circuit interval training still is utilized, with the patient encouraged to increase endurance to 20 minutes on one exercise unit and shorter interval sessions of 5 to 10 minutes on the other equipment. Repetition and resistance exercise levels again are increased accordingly.

At the end of the 12-week course, exercise capacity

and cardiac performance are re-evaluated. At this point, the patient may graduate into the phase IV program which is a continuation of phase III, utilizing similar guidelines, but carried out over a prolonged period. Exercise prescriptions are reviewed, and bimonthly progress reports are generated. The patient is involved with assessment and development of new goals or reaffirmation of existing goals.

Since its inception, no incident leading to death of a patient has occurred, and no noted myocardial infarction as a result of exercise has been reported. Incidents including chest pain and hypotension have occurred. However, they too have been infrequent. The dropout rate also has been very low, approximately 10 percent. The current adherence rate is at 90 percent, with 28 percent of patients opting to continue on from phase II into phases III/IV.

SUMMARY

The Cardiac Rehabilitation Program at Pascack Valley Hospital has served 476 patients successfully over the past nine years. Although first established to serve the cardiovascular needs of the patient in a phase II program, it now includes phases I, II, and III of rehabilitation. The program includes physical reconditioning, lifestyle adjustments such as dietary modification, smoking cessation, stress management, psychological

counselling, and patient and family education. All of these efforts are designed to increase patient self-confidence, sense of well-being, and ability to function independently despite the presence of cardiac disease. Through such a program, the community hospital is able to provide services beyond the acute care setting and to offer an invaluable service of rehabilitation and education to the patient and the community.

CONCLUSIONS

1. A hospital-based cardiac rehabilitation program can meet an important community need in cardiac management.

2. The program is safe as organized.

3. Monitoring allows for another parameter of observation during the phase II program. It detects unsuspected arrhythmias, and provides an increased sense of patient security. The safety perceived by the patient enables one to progress.

4. Cooperative effort between two hospitals can reduce unnecessary duplication of facilities.

5. Although patients may be sent from our community hospital to another facility for interventional therapy, they return to the community hospital for rehabilitation. Therefore, rehabilitation remains the major responsibility of the local community hospital in the care of the cardiac patient.

MATERNAL DEATHS IN NEW JERSEY*

GERARD F. HANSEN, M.D., M.P.H., AND THOMAS A. NOONE, M.D., NEWARK**

Seventeen maternal deaths were reported in 1986. Ectopic pregnancy, AIDS, sepsis, and amniotic fluid embolism were the major causes of maternal demise. Patients' lack of obstetrical knowledge, preventing them from participating in their own care, was a significant contributing factor to maternal mortality.

The Maternal Mortality Committee, a subcommittee of the Maternal and Infant Care Committee of the Medical Society of New Jersey, in conjunction with the Maternal and Child Health Program, investigates annually all maternal deaths that occur in New Jersey. Details of each maternal death are obtained from death certificates, maternity service reports, and direct reporting from health care institutions. Such reporting is mandatory under state regulation and all information reported to the New Jersey State Department of Health regarding specific individuals and cases is held confidential and is not open to subpoena as stated in NJSA 26:1A-37(a).

Each member of the subcommittee reviews one or two cases and summarizes the circumstances of each death based on the material available. Each summary then is presented to the entire committee and consultant staff at an annual meeting at the Medical Society of New Jersey; the meeting is open to interested members of the health professions.

A decision is made by consensus as to cause of death from an obstetrical standpoint and the degree of physician and/or patient responsibility for such an occurrence. With the luxury of hindsight, recommendations are suggested as to what action, if any, could be taken to decrease maternal mortality.

RESULTS

There were 108,446 live births in New Jersey in 1986.¹ Twenty-one deaths, which occurred in or out of the hospital to women who were pregnant or had been pregnant within 90 days of death, were reported to the New Jersey State Department of Health for evaluation.

Table 1 lists the classification and mortality rates using the format suggested by the American College of Obstetricians and Gynecologists.² The remaining statistical data are summarized in Tables 2 through 5.

A nonmaternal death is defined as the death of a gravid or recently gravid woman from causes not related to the pregnancy or its management. Of the four deaths reported, two were the result of traffic acci-

*This article is the result of work of the Subcommittee on Maternal Mortality and the New Jersey State Department of Health: James P. Thompson, M.D., chairman; Jerald R. Cureton, M.D.; Joseph DeStefano, M.D.; William Hartko, M.D.; Robert Malatesta, M.D.; Joseph Saladino, M.D.; Nicholas Salerno, M.D.; Artist Parker, M.D.; Mackrim Irian, M.D.; and Roberta McDonough, R.N.

**Dr. Hansen is associate professor of clinical obstetrics and gynecology at UMDNJ-New Jersey Medical School. Dr. Noone is chairman, Department of Obstetrics and Gynecology, Our Lady of Lourdes Medical Center, Camden. Correspondence may be addressed to Dr. Hansen, UMDNJ-New Jersey Medical School, 185 South Orange Avenue, Newark, NJ 07103.

TABLE 1
Classification and Mortality Rates

Live Births	108,446
Maternal Deaths	21
Nonmaternal	4
Indirect	11
Direct	6
Rate (indirect only)	10.1/100,000 live births
Rate (direct only)	5.5/100,000 live births
Rate (all causes)	16.6/100,000 live births

TABLE 2
Characteristics of Maternal Deaths by Race, Age, and Prenatal Care¹

Race	Number	Percent
White	7	41
Other	10	59
Age		
Less than 20	4	24
20-34	12	70
35-39	0	
Greater than 40	1	6
Prenatal Care		
None	1	6
Inadequate	0	
Unknown	2	12
Adequate	10	59
Excluded (abortion or ectopic)	4	23

¹Nonmaternal deaths excluded.

TABLE 3
Parity and Duration of Pregnancy¹

Parity	Number	Percent
0	6	35
1-3	9	53
4-6	2	12
Gestational Age		
Less than 20 weeks	7	41
20-28	0	
28-40	8	47
Postpartum	1	6
Postabortal	1	6

¹Nonmaternal deaths excluded.

dents. Both accidents were violent in nature and the use or nonuse of seat belts was immaterial. A third woman, 4 weeks postpartum, committed suicide with a revolver; this action was not related to her recent pregnancy. The fourth pregnant woman died in an accidental fall at home; no satisfactory cause of death was discovered.

An indirect maternal death is one resulting from a previously existing disease or a disease that develops during pregnancy, labor, or the puerperium which is

not directly due to obstetrical causes, but is aggravated by the physiological effects of pregnancy. There were 11 such deaths, 4 of which were deemed nonpreventable by present day standards of care.

One woman, three months pregnant, was found dead at home. An autopsy report revealed bilateral pulmonary embolism secondary to pelvic phlebotrombosis. A second woman, five months pregnant, died of viral pneumonia after a protracted hospital course. A third woman died of sickle cell crisis, 13 days after abortion and sterilization despite pre- and postoperative care. The fourth woman died of primary pulmonary hypertension following a caesarean section for cephalopelvic disproportion. Demise occurred several weeks postoperatively during evaluation at a tertiary care center.

Two women died of endocarditis during the second trimester.³ Both were intravenous drug users who failed to cooperate with their physicians. A third woman died of lobar pneumonia while six weeks pregnant; she had a history of fever, chills, and a cough for four days prior to her emergency room visit. Cardiac arrest occurred 25 minutes after admission to the emergency room. A physician factor was suggested in the death of the fourth woman who had an aortic valve replacement (porcine); antibiotic therapy was not continued for a sufficient period following a caesarean section complicated by endometritis and, subsequently, by endocarditis. A fifth woman died of sickle cell crisis at term; she refused blood transfusions based on religious beliefs. Two women died of AIDS, one after a delivery of twins in which the patient extubated herself while on a respirator; the other patient concealed delivery of a seven-month fetus in a hospital bathroom and shortly thereafter experienced cardiovascular collapse. These last two tragedies reflect the devastation of AIDS and the difficulty in caring for these patients.

A direct maternal death is an obstetrical death usually from complications of pregnancy, labor, or puerperium and from their intercessions, omissions, incorrect treatment, or a chain of events resulting from any of these complications.

Of the two deaths felt to be nonpreventable, one death was due to an amniotic fluid embolism post-caesarean section properly managed.⁴ She died 2 hours after delivery. The second patient died of a bleeding diathesis 20 hours after an amniotic fluid embolism following a spontaneous vaginal delivery.

Four potentially preventable deaths were investigated. The first death was due to the inability to effectively and efficiently intubate a patient with a retained placenta who required general anesthesia. In this instance, there was a failure to insure that the endotracheal tube was in the correct position after insertion.

One woman died of overwhelming sepsis 14 days after a second trimester abortion. Attempts by the patient to contact her primary obstetrician were unsuccessful. The patient also was seen in two separate emergency rooms but no appropriate treatment was started; on the patient's third encounter with physicians, antibiotics were prescribed.

A 17-year old black woman and a 19 year-old black woman died of ruptured ectopic pregnancies. Failure

of these women to be knowledgeable about the possibility of this serious condition was the major factor in their demise.

RECOMMENDATIONS

- 1. Human sexuality courses in high schools should include information about ectopic pregnancy and other hazards of pregnancy so that women may be meaningful participants in their care.
- 2. All physicians treating pregnant patients should be trained in emergency intubation. This includes methods of ascertaining the correct position of the endotracheal tube.
- 3. Primary physicians of pregnant women must be able to recognize and treat vigorously such medical conditions as endocarditis or to obtain competent medical consultation expeditiously.
- 4. Health care personnel must be trained to care for AIDS patients. This will require increased training as well as commitment of necessary funds and a decrease in nurse-patient ratio.
- 5. Obstetricians have an obligation to provide adequate coverage when they personally are not available to attend their patients.

SUMMARY

In 8 of the 17 maternal deaths, patient ignorance of medical facts that would have enabled them to seek medical attention was a significant factor in maternal mortality.

Sixty-five percent of maternal loss in New Jersey was due to conditions that were not of an obstetrical nature, but were medical conditions aggravated by the pregnancy.

AIDS now is an important factor in maternal and infant morbidity and mortality.

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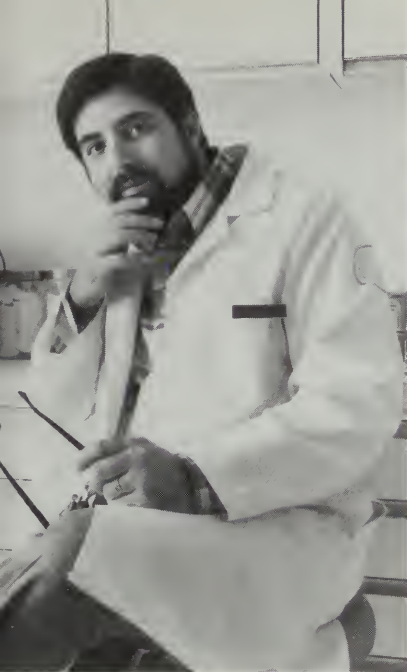
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TABLE 4			
Classification and Preventability			
Nonmaternal			4
Maternal			17
Indirect			11
Nonpreventable	4		
Preventable	7		
Direct			6
Nonpreventable	2		
Preventable	4		
Physician Factor			2
Patient Factor			9*
*In one death, physician and patient shared preventability.			

TABLE 5			
Causes of Death			
1. Nonmaternal Deaths			4
Auto accident	2		
Suicide	1		
Fall	1		
2. Maternal Deaths			11
A. Indirect			11
1. Nonpreventable			
Viral pneumonia	1		
Pulmonary embolus	1		
Sickle cell disease	1		
Primary pulmonary hypertension	1		
2. Preventable			
Sickle cell disease	1		
AIDS	2		
Endocarditis	2		
Lobar pneumonia	1		
Heart disease	1		
B. Direct			6
1. Nonpreventable			
Amniotic fluid embolus	2		
2. Preventable			
Ectopic pregnancy	2		
Anesthesia	1		
Infection postabortion	1		



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POSTOPERATIVE EPIDURAL NARCOTICS FOR VASCULAR SURGERY

ROBERT RAGGI, M.D., ENGLEWOOD*

Benefits of epidural anesthesia for vascular surgery include: blunting of surgical stress response, decreased incidence of thromboembolism and mortality due to pulmonary emboli, less blood loss, and cardiovascular stability in the geriatric population. If the epidural catheter is used, postoperative sympathetic blockade will protect against vascular spasm and provide acute postoperative pain relief.

A recent survey of anesthesiologists indicated that an overwhelming majority (92 percent) would prefer regional anesthesia for their own surgery.¹ Regional anesthesia has become the anesthetic of choice for many surgical procedures including cataract extraction, transurethral resection of the prostate (TURP), and hand surgery.² A recent accumulation of advantageous data merits a re-examination of the benefit/risk ratio of epidural analgesia for vascular procedures (Table 1). These advantages include metabolic stability, suppression of the surgical stress response (SSR), cerebral status monitoring, stability of high-risk patients with heart diseases, hypertension, diabetes, chronic obstructive pulmonary disease (COPD), or advanced age. Epidural anesthesia affords superior postoperative pain relief. This paper will show the advantages of epidural anesthesia combined with postoperative epidural narcotics.

METHODS

Informed consent was obtained from all patients in this study. Ninety-one patients were scheduled for lower extremity vascular surgery. The limb salvage procedures included femoral-popliteal, femoral-tibial, femoral-peroneal bypass grafts, and femoral endarterectomy with vein patch.

Associated diseases included arteriosclerotic cardio-

vascular disease, COPD, diabetes mellitus (DM), congestive heart failure (CHF), hypertension, prior myocardial infarction, prior coronary artery bypass graft (CABG), ectopic beats, smoking history, chronic renal failure (CRF), ST depression on the electrocardiogram (EKG), and prior cerebrovascular accident (CVA). All patients received preoperative preparation by their internist. Preoperative medication with diazepam (0.1-0.2 mg/kg) was given orally one to two hours prior to surgery.

Monitoring included EKG (lead II and modified V5), direct arterial line blood pressure, blood gases, precordial stethoscope, verbal contact, axillary temperature, urinary catheterization, intermittent pretracheal auscultation, and Swan-Ganz monitoring when indicated (16 percent). All patients received various amounts of intravenous sedation and two to four liters of oxygen via nasal cannula. Eight patients received supplemental light general anesthesia (various combinations of intravenous neuroleptic anesthesia, nitrous oxide/oxygen 2:1 with 0.25 percent forane, and/or diazepam) for patient anxiety, positioning, comfort, and amnesia. Baseline activated clotting time (ACT) was obtained and followed by heparinization.

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Intravenous volume loading was performed to prevent hypotension due to sympathetic block. Patients were positioned, prepped (betadine), and draped. Under sterile conditions, the most skilled anesthesiologist available administered local anesthetic skin wheal and infiltration injection at the most accessible lumbar interspace. With an 18 gauge Touhy needle, the epidural space was identified using the loss of resistance technique (LORT). After negative aspiration, a 3 ml test dose of 1.5 percent xylocaine with 1:200,000 epinephrine was injected. After three minutes, the anesthesiologist administered an anesthetic dose of 10 to 12 ml using bupivacaine 0.5 percent (84 percent) and 0.75 percent (7 percent), or xylocaine 2 percent (9 percent). A Teflon® epidural catheter was threaded, the disposable Touhy needle removed, and the catheter was secured with a sterile dressing. Further local anesthetics were given as "top-up" doses as needed through the catheter. Heparin was given intraoperatively after catheter placement.

Preservative-free morphine, 5 mg in 10 ml of sterile normal saline, was given at the conclusion of surgery (35 percent) or when the patients indicated pain (65 percent). Patients were instructed to request pain medication promptly as needed. They were monitored in the surgical intensive care unit by nurses familiar with this technique during, and 24 hours after, epidural narcotics. If the catheter was not functioning or relief was inadequate, then patients received oral or intramuscular narcotics.

RESULTS

Our series shows a zero incidence of epidural hematoma and myocardial infarction. There were five failed epidurals requiring general anesthesia. Six patients required ephedrine (5-10 mg) intravenously. No other vasopressors or afterload reducers were needed, attesting to the technique's hemodynamic stability. Postoperatively, 7 patients required diuresis for mild cardiogenic pulmonary edema. The epidural catheter was nonfunctioning in the first 24 hours in 6 patients, leaving 85 patients in the study group.

The onset of epidural morphine analgesia was consistent with other studies, i.e. 10 to 45 minutes.³ The mean analgesic duration was 15 hours, measured by requests for pain medication and nursing observation. At request for pain medication, a subsequent epidural morphine dose provided a smooth continuum of analgesia in the first 24 hours. Those patients who received epidural narcotic immediately postoperatively, within their first 16 hours, were virtually pain free. Eighty-five percent of patients received virtually complete analgesia with "top-up" doses of epidural morphine for 48 hours. Twelve patients suffered nausea and required Narcan® 7 to 10 hours postepidural morphine. Three patients vomited while receiving epidural morphine. Twenty-three patients needed Narcan® for pruritus. All patients had bladder (Foley) catheters in place so the possibility of urinary retention was not assessed. No patients had respiratory arrests (reported with higher doses of epidural morphine). Nine patients showed the side effect of respiratory rate decrease (seven to ten breaths per minute). However, with increased inspired oxygen, this was adequate ventilation not requiring naloxone reversal.

One patient suffered a subendocardial myocardial infarction three days prior to surgery requiring emergency surgery to prevent impending gangrene of his leg. He was given a combination epidural technique, had successful surgery, and did not extend his myocardial infarction.

DISCUSSION

Historically, the progress in vascular surgery and anesthetic technology has seen some parallel achievements. In 1884, Halstead performed the first neural blockade using cocaine.⁴

While performing end-to-end anastomosis and endoaneurysmorrhaphy in 1899, Dr. Rudolph Matas pioneered spinal anesthesia. He used a hypotonic solution of 10 to 20 mg of cocaine hydrochloride in distilled water.⁵ Also, utilizing the physiologic principles forwarded by Claude Bernard,⁶ René Leriche promoted surgical sympathectomy at the Strasbourg Vascular School in the late 1920s. The first reported lumbar epidural anesthetic was performed by Fidel Pages and published in the *Argentine Military Journal*.⁷ The popularization of this new technique for surgery was marked by Dogliotti's publication in Europe and in the *American Journal of Surgery* (1931).⁸ Since the beginning of this century, vascular surgery has been performed under spinal or general anesthesia, but until recently, the fear, risk, and taboo of epidural hematoma labeled epidural anesthesia as prohibitive.

VASCULAR SURGERY/EPIDURAL ANESTHESIA

There are some landmark articles that are noteworthy in the recent development of epidural anesthesia for vascular surgery.^{9,10} The classic article of Cousins and Wright demonstrated increased graft (Dacron®) blood flow after epidural sympathetic block.¹¹ Redistribution of the blood flow to the skin was achieved at the expense of the muscle. In the critical postoperative phase, vasoconstriction triggered by hypothermia and surgical manipulation may be relieved by sympathetic blockade. Distribution of blood flow to the lower extremities after epidural anesthesia has been shown to be due to decreased vascular resistance. In 1980, a review of 100 cases of abdominal aortic aneurysm repair using continuous epidural anesthesia combined with light general anesthesia, documented adequate operative conditions. No epidural hematoma nor any other anesthetic complication occurred.¹²

Epidural anesthesia has been recommended for aortofemoral aortography.¹³ It provides a motionless field for improved quality films, patient comfort, minimal cardiovascular stress, and minimum sedation. The enhanced flow to small arteries and collaterals yields superior radiographic studies. With the epidural catheter in place, these patients, supplemented by light general anesthesia, underwent vascular procedures. The authors noted rapid awakening, extubation, and no epidural hematoma. If further surgery is needed, the catheter allows reanesthetization.

Patients with coronary artery disease were given epidural anesthesia in a study that yielded dramatic results.^{14,15} Improvement in left ventricular function was demonstrated by increased left ventricular ejection fraction and improved regional cardiac wall mo-

tion. A more favorable myocardial oxygen supply/demand ratio is postulated. In experimental occlusion of the left anterior descending coronary artery, the effect of thoracic epidural was measured. The results showed a decreased size of the myocardial infarct and improved regional endocardial perfusion at the ischemic zone compared to the control group.¹⁶

In a group of 35 patients undergoing femoral-popliteal bypass, epidural anesthesia was followed by epidural morphine for postoperative pain relief.¹⁷ Five mg of morphine gave significant pain relief with no elevation of PaCO₂, or epidural hematoma. In a study of 30 patients, intrathecal morphine infusion (100 µg/hr) was given after coronary bypass surgery. The results showed effective pain relief, no epidural hematoma, minimal postoperative sedation, and early extubation (12 to 24 hours).¹⁸

METABOLIC RESPONSE

A further review of the benefits of regional anesthesia details the significant metabolic stability afforded. The most important is the blunting of the surgical stress response.^{19,20} Epidural anesthesia prepares a deafferented surgical site, which stops the nociceptive spinal excitability. In turn, this inhibits the stress elevation of the key trigger, catecholamines. Without this catecholamine explosion, there is blunting of its metabolic sequelae.²¹ Thus, the biologic signal, cyclic-AMP, which promotes cortisol and glucose elevation, is beneficially depressed. Another significant marker of blunted stress response is the lack of beta-endorphin elevation (Table 1).²²

The pituitary, renal, and adrenal hormones increase at a reduced rate under epidural anesthesia. Near normal levels of cortisol, renin, aldosterone, and growth hormone are noted with this technique.^{23,24} Elevations of plasma vasopressin (ADH) levels are reduced with epidural anesthesia.²⁵ General anesthesia depresses resting metabolic rate while epidural anesthesia does not.²⁶ The effect on pancreatic hormones tends to preserve glucose homeostasis. Hyperglycemia is further blunted by blockade of the hepatic sympathetic innervation and the adrenal medullary adrenergic release. Insulin is measurably lower during epidural anesthesia compared to general anesthesia. Diabetic patients are easier to manage by the inhibition of hepatic glycogenolysis.²⁷

Nitrogen sparing and improved postoperative nitrogen balance due to the inhibition of stress-released catabolic hormones are enhanced by epidural technique.²⁸ Immunosuppression is prevented by epidural anesthesia as manifested by the absence of lymphopenia and granulocytosis.²⁹

Various organ systems derive specific advantages during the epidural technique. The cerebral status can be monitored easily without the need for an electroencephalogram. The cardiac system enjoys improved left ventricular function, increased myocardial oxygen supply/demand ratio, less catecholamine stress, protection against hypertension after cardiac surgery, decreased mean arterial pressure (20 percent) afterload, and avoidance of the myocardial depressant effects of general anesthetics.

Studies have shown the most popular inhalation anesthetic, isoflurane, causes coronary artery steal.³⁰

TABLE 1

Benefits of Epidural Anesthesia

Endocrine
Inhibit surgical stress response
Inhibit adrenalin and cortisol release
Inhibit hyperglycemia
Inhibit lymphopenia and granulocytosis
Nitrogen sparing
Block sympathetic tone
Cardiovascular
Less myocardial oxygen demand and afterload
Decreased myocardial infarction size (experimental model)
Increased endocardial perfusion at ischemic zone
Less sympathetic blood pressure swings
Less blood loss
Less general anesthesia depressant medication needed
Redistribution of blood to lower extremities
Pulmonary
Decrease drop in FVC, FEV-1, PEFR
Less shunting, oxygen consumption
Improved A-V oxygen differences
Less pulmonary infections
Less thromboembolism
Renal
Increase blood flow renal cortex, less renal vascular constriction
Geriatric
Less cardiorespiratory trespass
Improved postoperative mental status
Miscellaneous
Earlier extubation, ambulation, and discharge
Greater postoperative pain control

TABLE 2

Risks		Epidural Hematoma Incidence
Authors	Cases	
Frumin, Schwartz, 1952	128	1
Dripps, Vandam, 1954	20,000	.01
Phillips 1969		
Bonica, 1953	3,637	
Spurning, 1964	*	43 (8)
Markham, 1967	*	49
Gingrich, 1968	*	1
Helperin, 1971	*	1
Lund, 1966	150,000	0
Cunningham, 1980	100	0
Rao, El-Etr, 1981	3,164	0
Odoom, Sih, 1983	1,000	0
Raggi, 1987	96	0

*Reviews of complication cases only.

Nitrous oxide, which is used in most general techniques, has been shown to cause pulmonary hypertension which is quite detrimental to the compromised cardiac patient.

Sympathomimetic-mediated reactive swings of blood pressure are avoided with regional technique.

Blood loss has been shown to be diminished by regional anesthesia during total hip replacement (35 percent), hysterectomy (44 percent), retropubic prostatectomy (37 percent),^{31,32} and transurethral resection of the prostate (18 percent). Epidural anesthesia decreases venous capacitance and circumvents the need for positive pressure ventilation with its increased venous pressures and consequent increase in blood loss.

Pulmonary function post-thoracotomy with a light general and epidural anesthesia reveals a smaller drop in FVC and FEV-1, smaller decrease in peak expiratory flow rate, and better pain relief.³³⁻³⁵ In morbid obese patients undergoing gastropasty, epidural analgesia provides decreased intra-pulmonary shunting, decreased arterial-venous oxygen differences, and oxygen consumption.^{36,37} Pulmonary infections and total complications are decreased by 8 percent in the epidural group. Continuous technique is more protective of pulmonary function than single dose blockade.³⁸

One of the most convincing arguments for regional anesthesia is the lowered incidence of thromboembolism. When epidural anesthesia compared to general anesthesia is studied by phlebography (I-125-fibrinogen scan), there is a striking reduction of deep venous thrombosis in the femoral-popliteal (54 percent) and calf and thigh (37 percent) region. Pulmonary embolism is reduced 23 percent after hip replacement under epidural anesthesia. There are data consistent with increased blood flow, less venous stagnation in the lower extremity, less clotting, and more efficient fibrinolysis.⁴⁰ Indeed, epidural anesthesia should be added to the thromboprophylactic armamentarium for high-risk patients and procedures.

Renal sympathetics blocked with epidural anesthesia help prevent renal vascular constriction and angiotension secretion.⁴¹ This block allows greater blood flow to the renal cortex without consequent natriuresis. Indicators of proximal tubular damage (lysozyme and ligandine) never were found in urine samples of the epidural group. Creatinine clearance remained lower in this group.

The disadvantages of general anesthesia are relevant to this discussion. Regional myocardial blood flow measured by radioactive microspheres exhibit coronary vasodilatation and coronary steal in patients with coronary artery disease. General anesthetics are negative inotropic drugs.^{42,43} Nitrous oxide promotes pulmonary hypertension and limits inspired oxygen concentration. Halothane and ethrane are arrhythmogenic and depressors of the hepatorenal functions. All of the general anesthetics including the induction agents (sodium pentothal and methohexital) are potent cardiorespiratory depressants.^{44,45}

GERIATRIC AGE GROUP

Many candidates for vascular surgery are in the high-risk geriatric age group. Mortality has been shown to be greater in this group, i.e. nonagenarians (9 percent), octagenarians (5 percent). This group exhibits a generalized deterioration of organ function. By age 75, there is a 35 percent decrease in cardiac output, 20 percent decrease in cerebral blood, and 55

percent decrease in renal blood flow.^{46,47} There is a marked decrease in the elasticity and compliance of blood vessel walls, which compromises flow patterns. Pulmonary elasticity, gas exchange, arterial oxygen tension, forced expiratory volume, and total reserve are decreased significantly in this group. Drug absorption, metabolism, and excretion are decreased. Drug effect, half-life, and availability are increased. Renal function shows redistribution of blood flow towards the medulla. Frequently encountered diseases include coronary artery disease, hypertension, chronic lung disease, diabetes, and renal disease. A preoperative visit with the elderly should elicit an assessment of whether exercise tolerance is limited by shortness of breath, chest pain, or leg pain.^{48,49}

Perioperative risk in the geriatric patient has been found to correlate with pre-existing disease, ability to exercise, e.g. greater than two minutes of bicycle exercise raising heart rate above 99 beats/minute, and expected degree of surgical stress. Judicious fluid titration is imperative as these patients have an increased risk of congestive heart failure and renal dysfunction. Geriatric patients have decreased morbidity if the anesthetic regimen eliminates the deleterious cardiac effects of nitrous oxide; the result is an increase in inspired oxygen content.⁵⁰

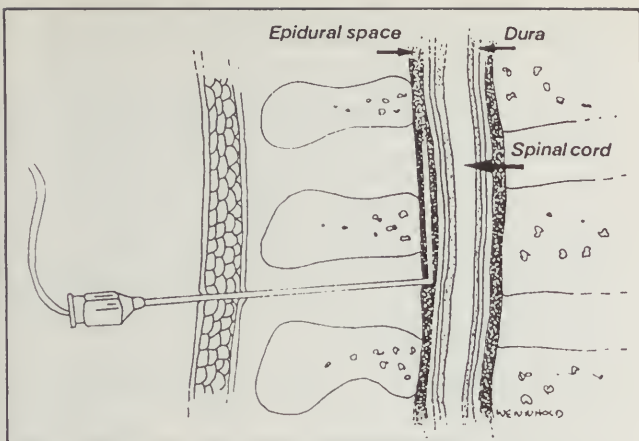
Regional anesthesia should be considered whenever possible for the geriatric patient due to its superior metabolic stability. The ophthalmologic literature is testimony to the desirability and safety of regional anesthesia in the high-risk patient population who undergo cataract surgery.

While intrathecal anesthesia provides superb somatic and motor block with minimal amounts of drug, epidural anesthesia induces a safer and more gradual onset of sympathetic blockade with better control of the risks of hypotension and bradycardia. Epidural dose is decreased with age. There is an additional benefit of decreased risk of nosocomial infection risk with ambulatory surgery which is ideal for regional techniques.

EPIDURAL HEMATOMA

The crux of this discussion hinges on whether this is a safe enough technique to merit a rethinking of traditional teaching. Recently, authors indicate this to be the case. While hematoma is not the only complication of epidurals, it is the most serious concern with its use in vascular surgery. Symptoms of urinary and/or fecal incontinence, severe low back pain, and sensory and motor deficits warn of this complication and need for urgent myelography and surgical decompression. The evaluation of the patient is improved with postoperative epidural morphine analgesia compared to epidural somatic block.

Various authors have reported cases of this devastating complication. While many of these are spontaneous, there is an increased risk in patients⁵¹⁻⁵³ with blood dyscrasias, hemophilia, leukemia, thrombocytopenia, alcoholism, anticoagulation, spinal canal neoplasm antiplatelet therapy, and difficult traumatic epidural technique.⁵⁴⁻⁵⁶ There also are neurologic deficits caused by the unrelated etiologies of spinal artery spasm, hypotension, intrathecal preservatives or detergents, and highly acidic preparations.



Figure—Postoperative epidural analgesia after peripheral vascular surgery. (Credit: Ann Wennhold)

However, the rarity of epidural hematoma is revealed in the perspective of the larger series of patients.⁵⁷ In the summation series of Dripps, Philips, Lund, and colleagues, the risk is less than .01 percent (Table 2).⁵⁸ In the more recent series of Odoom, Rao, Allen, Cunningham, and Raggi,^{59-61,63} there were no cases of epidural hematoma in the vascular surgical patients with anticoagulation therapy. This may be due to luck or a quirk of statistics. Alternatively, this may be the combination of the rarity of this risk with improved soft, atraumatic catheters, increased knowledge and skill of technique, increased monitoring and suspicion of this risk, and level of anticoagulation.⁵⁹⁻⁶¹ While the caution for epidural technique prior to anticoagulation remains, it no longer appears to be an absolute contraindication. In fact, with the emerging epidural narcotic technology, and the continued catheter and monitoring improvement, the benefit/risk ratio may be further shifted.

EPIDURAL NARCOTICS

Since the classic studies of Blume (1927) and Brooks (1937), opiates have been known to have a central nervous system receptor. In 1981, Kitahata, demonstrated a spinal avidity of opioids by iontophoretic application. This spinal opiate receptor was described by Snyder, Stoeltling, and others.^{62,63}

Wang reported the first clinical use of intrathecal morphine (1 mg) in chronic intractable malignant pain.⁶⁴ Behar reported the first clinical use of epidural morphine for acute and chronic pain.⁶⁵ Yaksh and Cousins have contributed extensive reviews which have aided understanding and stimulated research.^{62,66} In Cousins's review, epidural narcotics are cited for use in most areas including open heart surgery, thoracotomy, orthopedic surgery, abdominal surgery, chronic pain due to cancer or other conditions, and even acute medical conditions such as myocardial infarction or thrombophlebitis.

Inadequate, sporadic postoperative analgesia has continued to be a problem for modern medicine and a primary concern for patients. This is exemplified by the avalanche of clinical research trials of this new technique. Major vascular procedures, with their intrinsic high-risk geriatric and cardiac group,⁶⁷⁻⁷⁰ are a glaring omission in these early studies. This report and Allen have shown that the use of epidural nar-

cotics allows superior analgesia after vascular procedures with minimum risk.

Epidural narcotics afford selective analgesia without sympathetic sensory or motor blockade. The pharmacokinetic model proposes transport of the opioid from the epidural space to the spinal cerebrospinal fluid (CSF). This is achieved by vascular uptake via the segmental posterior radicular arteries and also by the transfer across arachnoid granulations near the dural cuff. Once in the CSF, the unionized narcotic binds to the site of action or the opiate receptor in the substantia gelatinosa of the dorsal horn. The ionized hydrophilic molecule is available for the rostral spread responsible for the side effect.

The incidence of side effects such as nausea, vomiting, pruritus, urinary retention, and respiratory depression vary with dosages and clinical study. Nausea and vomiting (17 to 50 percent) occur about eight hours after epidural morphine⁷³ and coincide with the rostral spread to the chemoreceptor trigger zone. Pruritus (28 to 100 percent) is due to histamine release three hours after epidural morphine and is severe in 1 percent of patients. Urinary retention (20 percent) is due to inhibition of the detrusor muscle. It is not a factor in catheterized vascular patients. Respiratory depression has a dual peak onset. The first refers to high plasma levels about 30 minutes after injection. The second more insidious factor is due to the cephalad spread in the CSF to the fourth ventricle 6 to 22 hours postinjection. This respiratory depression can be manifest by an increased end-tidal carbon dioxide level, a decreased ventilatory response to carbon dioxide, or apnea. This last situation necessitates the use of special monitoring by trained nurses, the intensive care unit setting, and/or apnea monitors. In addition, there have been very rare isolated cases of dysphoria, sedation,⁷⁴ and catatonia not unlike traditional narcotic overdose. All of these side effects may be treated by small doses of naloxone while preserving the analgesia. Patients with chronic high-dose treatment show tolerance to these side effects.

The effective dose⁷⁵ of epidural morphine after vascular procedures is 5 mg in 10 ml of normal saline (available in a FDA-approved preservative-free preparation). A higher dose affords equal analgesia and a higher incidence of side effects. The complete onset of epidural morphine may take 40 minutes. The duration varies from 6 to 36 hours with a mean of 15 hours.⁷⁶ Epidural sublimaze (0.1 mg) affords a quicker onset (4 to 10 minutes), less side effects, but much shorter duration (2.5 to 4 hours).^{77,78} This quick onset may be a benefit in fragile cardiac patients in acute pain. Epidural narcotics have been shown to be more effective than the technology-dependent patient controlled analgesia (PCA).^{79,80}

The excitement over this technique is easy to understand. The pain-free postoperative state can be approached if the epidural narcotic is given while the sensory block still is intact. In this way, the metabolic and other benefits of epidural anesthesia can be combined with a pain-free postoperative course in this vulnerable patient population.

SUMMARY

A series of 91 cases for peripheral arterial re-

construction managed with continuous epidural anesthesia and postoperative epidural narcotics is reviewed. The incidence of myocardial infarction, epidural hematoma, and thromboembolism was zero. Pain scores for the first ten hours show 90 percent of cases were pain free.

The postoperative sympathetic blockade improves graft flow. Added to the complete postoperative analgesia, this is shown to benefit both cardiac function and endocrine stress response.

Epidural anesthesia and postoperative epidural narcotics provide a safe and reliable method of management for patients undergoing vascular procedures.

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CASE REPORT: MULTIPLE MYELOMA COMPLICATED BY *HAEMOPHILUS PARAINFLUENZAE* ENDOCARDITIS

MOREY MENACKER, D.O., AND RICHARD SCHER, D.O., HACKENSACK*

A patient with multiple myeloma developed Haemophilus parainfluenzae endocarditis prior to chemotherapy. Haemophilus is an uncommon cause of endocarditis, but it can infect previously normal valves. In immunodeficient patients with Haemophilus sepsis, endocarditis should be considered.

Infections are common complications of multiple myeloma, a well-described plasma cell neoplasm.^{1,5} It has been estimated that the incidence of all types of infection is 1.46 per patient-year, with the greatest period of risk during initial chemotherapy (4.86 per patient-year).⁶

Streptococcus pneumoniae is the organism classically known to be associated with infections in patients with paraproteinemias; however, gram-negative organisms are the most common bacterial isolates found.^{1,4,5} A case is described in which a patient with multiple myeloma developed an unusual infectious process prior to the initiation of chemotherapy.

CASE REPORT

A 55-year-old man was admitted to the emergency room with shortness of breath and fever. Dyspnea was episodic, but increasing in severity and duration over the four weeks prior to admission. The patient denied any significant past medical history other than smoking one pack of cigarettes daily and drinking one pint of whiskey weekly. Physical examination revealed a blood pressure of 128/80, temperature of 101°F, pulse of 120/minute and regular, and respirations of 30/minute. The cardiovascular examination revealed an S3 gallop, but no thrills, rubs, or murmurs. Bibasilar rales were heard in the lungs. The abdomen

was soft, with a liver measuring 20 cm in the mid-clavicular line.

The initial blood count revealed a hematocrit of 15.7 and a leukocyte count of 12,600 with 52 percent neutrophils, 3 percent band forms, 34 percent lymphocytes, 2 percent monocytes, 1 percent eosinophils, 1 percent atypical lymphocytes, 5 percent plasma cells, 1 percent metamyelocytes, and 1 percent myelocytes. The electrocardiogram (ECG) was interpreted as sinus tachycardia with a normal axis.

The patient was in congestive heart failure; a consideration of a hematologic malignancy was entertained on the basis of the grossly abnormal blood smear. Blood, urine, and sputum cultures were obtained to rule out sepsis. The patient was treated with diuretics and transfused packed red blood cells for congestive heart failure and anemia.

The patient improved following treatment. A bone marrow aspirate and biopsy were packed with plasma cells. Urine and serum protein electrophoresis displayed monoclonal IgG kappa spikes, and a quantitation of serum IgG was 9840 mg/dl (563 to 1765 mg/dl is normal). Blood cultures from admission grew *Haemophilus parainfluenzae*.

On the third hospital day, the patient developed a

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blowing early diastolic murmur over the aortic area. An echocardiogram revealed a large vegetation on the aortic valve leaflet. The patient was treated for *Haemophilus* endocarditis with ampicillin. Melphalan and prednisone were initiated to treat multiple myeloma. The patient clinically improved, but succumbed to his neoplasm three months after initial diagnosis. Autopsy revealed fibrosis of the aortic non-coronary cusp without perforation. Microscopic examination failed to reveal evidence of acute infection and no pre-existing valvular abnormality was evident.

DISCUSSION

Haemophilus parainfluenzae is a well-described, uncommon cause of bacterial endocarditis. In a large series, all *Haemophilus* species accounted for only 1 percent of documented bacterial endocarditis.⁷ Lynn reviewed the literature and found 35 cases of *Haemophilus parainfluenzae* endocarditis from 1928 to 1975.⁸ The median age was 27 years, with 56 percent of infections occurring on previously normal valves. Two-thirds of the patients lacked a predisposing illness, e.g. dental manipulation, pneumonia, or respiratory infection, and no evidence of immune deficiency was noted.

Haemophilus organisms are considered normal flora of the nasopharynx and oropharynx;⁹ these are the portals of entry to the blood or lung in causing infection.

A biphasic pattern of infection in myeloma patients has been reported, with *Streptococcus pneumoniae* and *Haemophilus influenzae* occurring at presentation, and *Staphylococcus aureus* and gram-negative bacilli being reported later in the course of disease, as a major cause of death.¹⁰ Infections with polysaccharide-encapsulated organisms appear to be related to the functional hypogammaglobulinemia seen in multiple myeloma patients, as well as a poor antibody response to antigenic stimulation.^{2,4} The emergence of gram-negative bacilli as the major infectious complication in myeloma correlates well with their role as the most common nosocomial infectious agents.^{1,4,5,10}

Infective endocarditis is a diagnosis made on clinical grounds. The sine qua non for the diagnosis is positive blood cultures; however, culture negative endocarditis is a well-known entity.¹¹ The characteristic findings of heart murmur, Roth spots, Janeway lesions, and Osler nodes are helpful; absence of any or all of these findings does not rule out the diagnosis. Echocardiography, M-mode, or 2-D are valuable in documenting valvular vegetations, but lesions less than 5 mm most often are missed.¹² The diagnosis of endocarditis must be suspected in patients with septicemia without source, or evidence of one of the four major clinical manifestations: infectious process on a cardiac valve, embolization, metastatic infection, or deposition of or circulating immune complexes.¹¹

Septicemia is a common complication of multiple myeloma; endocarditis rarely is reported^{1,5,13} for two reasons: endocarditis in this setting is underdiagnosed and endocarditis is less likely to occur in patients with myeloma. This may be related to the immunologic abnormalities inherent of plasma cell dyscrasias.

The pathogenesis of infective endocarditis involves a sterile platelet-fibrin thrombus, bacteremia, and a high titer of agglutinating antibody for the infecting organism.¹⁴ The platelet-fibrin thrombus evolves at the site of previous cardiac damage. Large numbers of bacteria are required to adhere to the thrombus, and clumping of organisms by agglutinating antibodies is the mechanism involved. Endocarditis of a previously normal valve requires a more virulent strain of bacteria, and a platelet-fibrin thrombus may not be as essential. However, high titers of antibody are required to insure adequate numbers of bacteria.¹⁴

Patients with multiple myeloma are functionally hypogammaglobulinemic and, therefore, may be unable to develop sufficient bacterial clumping for valvular infection to occur.²

SUMMARY

Infectious complications with nosocomial agents are a major concern in immunodeficient patients. However, one should be aware of other polysaccharide-encapsulated organisms, such as *Streptococcus* and *Haemophilus*, infecting multiple myeloma patients during their initial presentation or clinical remission.

The diagnosis of endocarditis is rare in patients with multiple myeloma. This may be related to inappropriate antibody production seen in plasma cell neoplasms.² *Haemophilus parainfluenzae* can infect normal cardiac valves.⁸ Endocarditis should be considered in immunodeficient patients with *Haemophilus* sepsis.

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CITIZEN'S AWARD: THE RIGHT QUESTION

CHUCK HARDWICK, TRENTON*

Assembly Speaker Chuck Hardwick was the recipient of the Citizen's Award from the Academy of Medicine of New Jersey. The award is presented to the citizen of New Jersey who merits recognition for distinguished service in the interest of health and welfare of the community at large.

I want to thank Dr. Paul Hirsch for nominating me for this award and for presenting it to me tonight. I have to tell you that this award means as much to me as any I have received. I value it because I value the support of those of us in public life who are trying to preserve and improve what is, after all, the best medical system on earth.

I would like to begin my remarks this evening with a story that has a point. I grew up in a small town in Kentucky, where farmers come in on Saturdays to do a little business and to catch up on the local news.

Well, one day, a stranger came to town, walked around for a bit, and then sat down on a bench next to a farmer and a dog. "Your dog bite?" he asked the farmer. "No." So the stranger reached down to pat the dog. The dog growled, bit into the man's arm, and nearly tore it off. He finally pulled himself loose from the dog's jaw, and he wailed to the farmer, "Hey, I thought you said your dog didn't bite." "Ain't my dog," said the farmer.

The point is that you have to ask the right question if you hope to get the right answer. I think we've been asking the wrong question about medical costs in this country. We've been asking: "How can we lower medical costs?"

That's not the right question. The right question is: When I'm sick, or when someone I love is sick, will we



*Assembly Speaker Chuck Hardwick (R) received the 1988 Citizen's Award from the Academy of Medicine of New Jersey. This essay was Speaker Hardwick's acceptance speech. Assemblyman Hardwick was first elected to the State Assembly in 1977 and recently was re-elected to his sixth term.

get the best possible care? From a public policy standpoint, the question is: Are the people of the state getting good medical value for their money?

This is not so unusual a question. In education, if we spend more, we are said to do a positive thing. But in medicine, if we spend more, brows furrow. Why? In education, we spend more because we believe there is a relationship between dollars and quality. But we seem perfectly willing to lower health care costs at any cost, including quality.

But, of course, the health care field is wider than hospitals. A recent survey of 14 prominent pharmaceutical companies in New Jersey showed that they employ 46,000 employees, generating sales just from New Jersey facilities of well over \$7 billion; just their research and development at New Jersey facilities total more than \$16 million.

These statistics have a story to tell about quality health care that is improving the lot of every New Jersey, even those who are not ill. We need to do everything we can to turn perceptions around. Health care dollars are not like tax dollars. State government does

not create the wealth that makes our people prosper. Health care dollars, on the other hand, stimulate the economy, creating jobs, investment, and above all, opportunity.

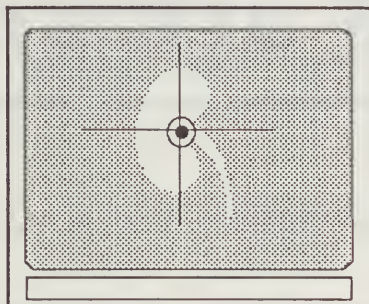
Though I go by the name of Chuck, my real name is Charles Leighton. As with so many of my generation, I was named after the doctor who delivered me. Not many people name their babies after trial attorneys.

We have in this country the greatest medical care in the world, or for that matter, in history. The debate about health care dollars has been asking the wrong question. When we ask the right question, we begin to see what our dollars are buying for us. And when we understand that, then we'll stop trying to make the medical profession into some kind of blue-plate special, and enjoy the medical care which, after all, is at the very foundation of what we call the American Dream.

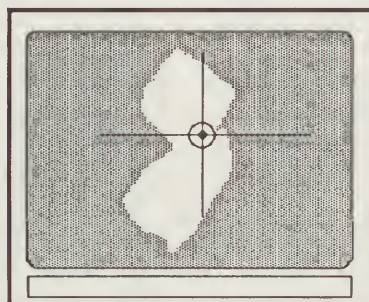
When I'm sick, I want the best possible care—and, I firmly believe, so do the rest of the people in this great state.

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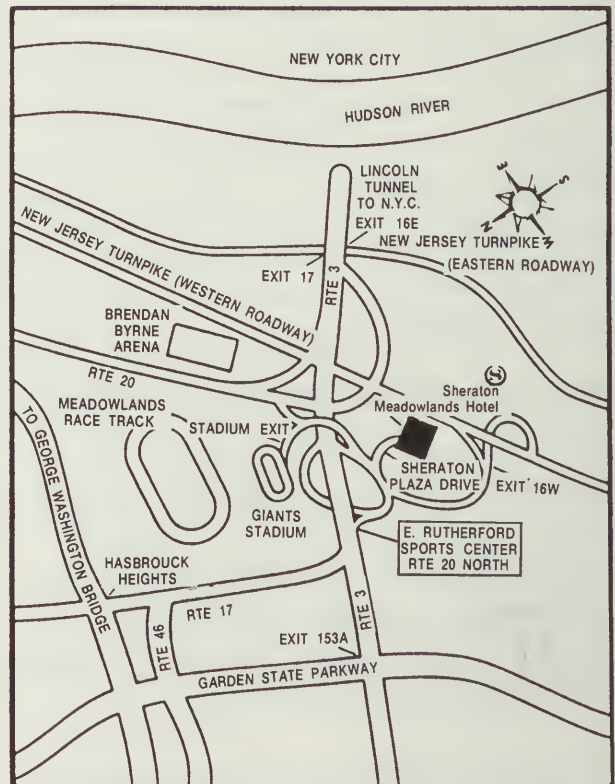
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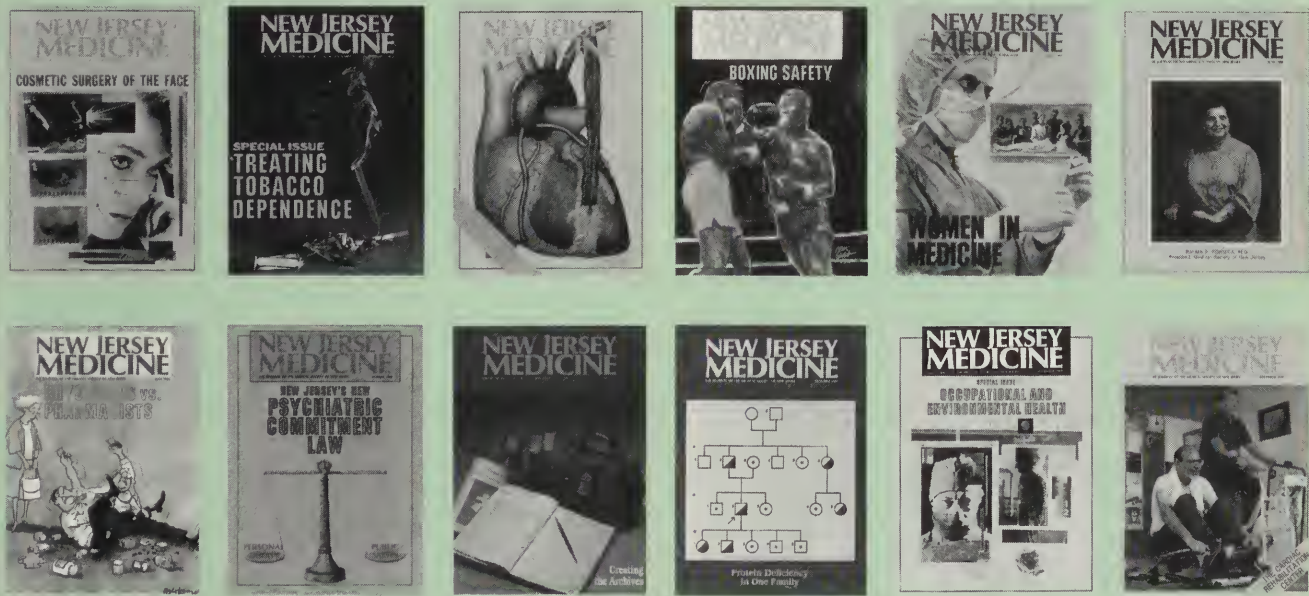
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AUTHOR INFORMATION

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CONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable

manuscript based on a presentation made in New Jersey.

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SPECIFICATIONS

Submit two **manuscripts** that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods used in articles should be identified. Acknowledgements will be made only for specific preparation of an essential part of the manuscript.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The **title page** should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 40-word **abstract** to be used at the beginning of the article.

Tables must be typewritten and double-spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the

source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The **summary** of the article should not exceed 250 words; it should contain only essential facts.

References should not exceed 35 citations except in review articles, and should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8½" by 11" sheets in the numerical order in which they are first cited in the text. The style of reference is that of *Index Medicus*:

1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Editorial Board. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors.

REPRINT ORDERS

Reprints may be ordered after the author is notified that the article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

COMMUNICATIONS

All communications should be sent to the Editor, *New Jersey Medicine*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

DOCTORS' NOTEBOOK

Trustees' Minutes; UMDNJ Notes; Physicians Seeking Location in New Jersey

Trustees' Minutes: October 16, 1988

A regular meeting of the Board of Trustees was held on October 16, 1988, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society; a summary of significant actions follows:

President's Report . . .

(1) AMA Meeting on Relative Value Scale Proposal . . . Noted that this proposed system by the Health Care Financing Administration will be discussed on November 13 and at the AMA Interim Meeting in December.

(2) NJ State Nurses Association . . . Welcomed Barbara W. Wright, R.N., executive director of the Nurses Association.

Report of Executive Director . . .

(1) MSNJ Financial Statements . . . Reviewed and approved the financial statements for the period ending September 30, 1988.

(2) Current AMA Litigation . . . Noted the following cases: (a) Missouri Supreme Court. The AMA filed an amicus brief urging the Supreme Court to uphold the decision of the circuit court; the family of a patient

in a persistent vegetative state requested permission to remove the nasogastric tube. (b) Court of Appeals, District of Columbia. The AMA joined with the American College of Obstetricians and Gynecologists in support of the appellants' position that a pregnant woman has a fundamental right to refuse medical treatment that poses a significant danger to her health. (c) Court of Appeals, Seventh Circuit. The 12-year-old antitrust suit by chiropractors against the AMA and other health care groups will be argued; the federal district court delivered a decision which found the AMA in violation of antitrust laws and the AMA was required to publish the court injunction in JAMA. The AMA has appealed. (d) Medically Unnecessary Determinations by Medicare. The AMA may challenge medically unnecessary determinations.

(4) Licensing Reform Legislation—S-2936 . . . Was informed that Mr. Maressa will notify the Board when a committee hearing is called to discuss this bill.

(5) Malpractice Surcharge Hearing . . . Noted that Drs. Formica and Riggs and Mr. Maressa will testify at the public hearing on the malpractice surcharge.

(6) Pending Appointments by Governor . . . Noted that the Executive

Committee will review all resumes and submit appropriate recommendations to the governor before October 31 for positions on the Cancer Research Committee, the Council on Medical Waste, and the State Board of Medical Examiners.

(7) Relative Value Scale Study . . . Referred the resource-based relative value scale proposal for review and report back to the Board.

UMDNJ Report . . . Noted the following items of interest from the report by Dr. Stanley Bergen: Dr. Norman Edelman has been appointed dean of the Robert Wood Johnson Medical School; and the Environmental and Occupational Health Sciences Institute is studying health problems resulting from exposure to benzene in the workplace.

NJ Hospital Association Report . . . Noted the following items of interest from the report by Louis Scibetta: (1) the problem for hospitals is staffing which translates into a need for salary increases; (2) the licensing standards for New Jersey hospitals are undergoing revision by the Department of Health; (3) the federal \$30 million grant for AZT treatment expired on September 30, 1988; (4) no evidence of favoritism alleged in the New Jersey home certificate of

CANDIDATES FOR MSNJ OFFICES

If you are interested in becoming an Officer, Trustee, or member of the AMA Delegation, a new opportunity exists for you.

The Nominating Committee will meet several times this year to consider candidates. We will consider members other than those recommended by county medical societies and nominating delegates for any of these offices.

If you wish to be considered, please contact your county medical society or the Medical Society of New Jersey for the necessary forms.

This is a real opportunity for grassroots candidate development and we urge you to use it.

need process was uncovered; (5) a New Jersey aeromedical network soon will become operational and initially the program will focus on prehospital and interhospital trauma and burn patient transfers; (6) and any refinement to the DRG system would be applauded by NJHA, particularly as it affects the reimbursement process.

Pennsylvania Blue Shield . . . Noted the informational network for Pennsylvania Blue Shield has been set up and is proceeding on schedule.

Council on Legislation . . .

(1) Current State Legislation . . .

Approved all the positions recommended by the Council, with the exception of the following: (a) A-2070—Drug Abuse (requires the Department of Health to prepare and physicians to distribute, a book-

let concerning the dangers of using cocaine during pregnancy); referred back to the Council for rewording of their reason for disapproval. (b) A-2485—Financial Interests in Referred Services (requires physicians, chiropractors, and podiatrists, when referring patients for services to a practice where they have a significant interest, to disclose that fact to the patient); position changed to active support.

(2) Certification of Review Organizations—Resolution #9 . . .

Approved the following recommendation:

That the Board of Trustees seek the introduction and passage of the legislation drafted in response to Resolution #9 of the 1988 House of Delegates.

Council on Public Relations . . .

Noted that the Council will incorporate messages on teen suicide,

depression, and panic anxiety disorders into their public service announcements.

Task Force on the Shortage of Nurses and Technical Personnel . . .

(1) Acute Care Nursing Assistant Program . . . Approved the following recommendation:

That the Society endorse the proposed Acute Care Nursing Assistant Program of the UMDNJ Department of Nursing Education and Services, and encourage the development of similar programs in New Jersey.

(2) AMA Registered Care Technologist Proposal . . .

Adopted the position that the AMA registered care technologist proposal should not be implemented in New Jersey at this time.

New Business . . .

(1) Decisions To Withdraw or

1989 MSNJ Annual Meeting

The Board of Trustees of the Medical Society of New Jersey at its September 18, 1988, meeting, approved the Committee on Annual Meeting recommendation that the 1989 Annual Meeting be held at the Sheraton Meadowlands Hotel in East Rutherford, on Thursday, April 27, through Sunday, April 30, 1989.

The daily schedule follows:

Wednesday, April 26, 1989

3:30 P.M. Board of Trustees' Meeting

Thursday, April 27, 1989

8:00 A.M. Registration Opens
8:00 A.M. Message Center Opens
10:00 A.M. House of Delegates
1:00 P.M. Program—Topic of Major Interest to Physicians
1:00 P.M. Exhibits Open
3:30 P.M. Reference Committee Meetings

Friday, April 28, 1989

8:00 A.M. Registration Opens
8:00 A.M. Message Center Opens
8:30 A.M. Exhibits Open
9:00 A.M. House of Delegates (Election)
12:00 NOON Golden Merit Award Ceremony and Reception
2:30 P.M. Reference Committee Meetings
5:00 P.M. JEMPAC Political Forum

Friday, April 28, 1989

5:45 P.M. JEMPAC Wine and Cheese Reception
6:30 P.M. Middlesex County Medical Society Reception

Saturday, April 29, 1989

8:00 A.M. Registration Opens
8:00 A.M. Message Center Opens
8:30 A.M. Exhibits Open
9:00 A.M. House of Delegates
1:30 P.M. House of Delegates
2:00 P.M. Exhibits Close
6:00 P.M. Inaugural Reception and Dinner

Sunday, April 30, 1989

8:00 A.M. Registration Opens
8:00 A.M. Message Center Opens
8:30 A.M. General Session—Topic of Major Interest to Physicians
1:00 P.M. Board of Trustees' Meeting

The daily schedule for Thursday, April 27 has been revised. Changes include the scheduling of the House of Delegates opening session at 10:00 A.M. on Thursday, April 27, 1989, and an educational program from 1:00 P.M. to 3:00 P.M., that same day.

The topics for the education programs scheduled for 1:00 P.M., Thursday, April 27, and 8:30 A.M., Sunday, April 30 will be announced at a later date.

The Inaugural Reception and Dinner-Dance honoring President-Elect Paul J. Hirsch, M.D., will be held on Saturday, April 29, 1989.

Withhold Life-Sustaining Medical Diagnosis or Treatment from Patients Age 60 and Over . . . Asked the Committee on Biomedical Ethics to review and offer an opinion on a letter from the Office of the Ombudsman for the Institutionalized Elderly concerning the mandatory reporting of adult abuse law.

(2) Tribute to Dr. Triebenbacher . . . Unanimously endorsed Dr. Hirsch's request that the editorial in the October 1988 issue of *NEW JERSEY MEDICINE* be framed and forwarded to Mrs. Triebenbacher.

UMDNJ Notes

**Stanley S. Bergen, Jr., M.D.
President**

The University of Medicine and Dentistry of New Jersey marked another milestone in its progress toward national prominence with its designation as a national "center of excellence" for environmental research.

I joined with officials of Rutgers University and the state and federal governments at our Piscataway campus to announce the Environmental and Occupational Health Sciences Institute (EOHSI)—operated jointly by UMDNJ and Rutgers—has received a \$5 million grant to create New Jersey's first National Institutes of Health (NIH) center of excellence.

The center is only the 11th in the nation designated by the NIH-National Institute of Environmental Health Sciences. Its mandate is to explore the health effects of human exposure to chemicals in the air, water, soil, and food through research in: biochemical mechanisms of toxicology and carcinogenesis; cellular mechanisms of toxicity and carcinogenesis; nutritional impact on toxicity and carcinogenesis; human exposure; and neurotoxicology.

The new center will comprise 30 scientists, including toxicologists, biologists, and chemists working on more than 50 research projects including:

- A study of how benzene is metabolized in the body, causing such diseases as anemia and leukemia.
- Research on how the liver is affected by certain hydrocarbons emitted from automobile exhausts, woodburning stoves and industrial processes.

- A project to monitor correlations between levels of a certain hydrocarbon in food, water, and air with chemical levels found in human blood and urine samples.
- An assessment of the role of nutrition in both promoting and inhibiting the development of malignant tumors.
- An exploration of how toxins affect the ability of nerve cells to transmit messages.

Since its inception in 1986, and under the expert leadership of Dr. Bernard Goldstein, EOHSI has emerged as a national pacesetter in environmental health sciences.

I'd like to spotlight two recent important appointments at our Newark campus, for they underscore our continuing commitments to science and to the communities we serve.

In the scientific realm, we welcomed an acclaimed research scientist to UMDNJ as professor and chairman of the Department of Microbiology and Molecular Genetics at the New Jersey Medical School.

Dr. Harvey Ozer's research into the effects of cell growth on cancer and aging is nationally recognized and receives ongoing support from the National Institutes of Health. A graduate of Harvard University and the Stanford Medical School, the physician-scientist joins us from City University of New York's Hunter College, where he was Thomas Hunter Professor of Science and Mathematics, a professor of biochemistry and biology in CUNY's graduate programs, and coordinator for the Center for Gene Structure and Function.

New to the position of assistant dean for minority affairs, but certainly not new to the medical school, is James Foster, a public health educator and community coordinator who has served here for two decades. During this time, Mr. Foster had spearheaded scores of community-based health care programs that have helped bring such major health problems as hypertension and childhood lead poisoning under control in Newark.

Mr. Foster, who holds a graduate degree in public administration, is concentrating on minority affairs, including student recruitment and academic and financial counseling, as well as programs for the Department of Preventive Medicine and Community Health.

**Physicians Seeking
Location in New Jersey**

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. For more information, contact the physician directly.

ANESTHESIOLOGY—Michael Silverberg, M.D., 2020 Walnut St., Apt. 29K, Philadelphia, PA 19103. Yale 1983. Board eligible. Available July 1989.

FAMILY PRACTICE—Neil S. Skolnik, M.D., 1114 Spruce St., Philadelphia, PA 19107. Emory 1984. Board certified. Group or partnership. Available.

INTERNAL MEDICINE—Diane Barton, M.D., Village of Stoney Run, Apt. 571, Maple Shade, NJ 08052. Temple 1984. Board eligible. Group, partnership, solo. Available July 1989.

Michael T. Burgio, M.D., 54 Jefferson Ave., Pompton Lakes, NJ 07442. St. George's 1985. Board eligible. Group or partnership. Available July 1989.

Rekha B. Daftary, M.D., 5 Willow Dr., Chester, NJ 07930. Kasturba (India) 1980. Board eligible. Partnership or group. Available.

Chris William Fellin, M.D., 135 Manning Terrace Apts., Danville, PA 17821. Hahnemann 1986. Board eligible. Partnership or group. Available July 1989.

NEURORADIOLOGY—Jerome G. Wiot, M.D., 803 East 6th St., #401, Newport, KY 41071. Cincinnati 1982. Board certified. Group or academic. Available July 1989.

NEUROSURGERY—Hae Dong Jho, M.D., Ph.D., 8327 Elaine Dr., Pittsburgh, PA 15237. Chonnam University 1971. Board eligible. Group, partnership, solo. Available June 1989.

OPHTHALMOLOGY—William Brian Neusidl, M.D., 200 Riverfront Pk., Apt. 13C, Detroit, MI 48226. Temple 1984. Board eligible. Available July 1989.

ORTHOPEDICS—Joseph M. Grant, M.D., Naval Hospital, Box 8, FPO, San Francisco, CA. UMDNJ 1980. Board eligible. Group or partnership. Available July 1989.

PEDIATRICS—Elizabeth Lubas, M.D., 508 Third St., Lyndhurst, NJ 07071. Boston University 1986. Board eligible. Group or partnership. Available.

Leena D. Parikh, M.D., 1290 Twin Streams Dr., Warminster, PA 18974. B.J. Medical (India) 1972. Board eligible. Group, partnership, solo. Available January 1989.

SURGERY—M. Amawi, M.D., 1904 Barham Blvd., Dodge City, KS 67801. Board certified. Group or partnership. Available.

THE PHILADELPHIA HEART INSTITUTE
of Presbyterian-University of Pennsylvania Medical Center

CARDIOLOGY UPDATE

designed for the physician and provides an intensive survey of the
current status of clinical cardiology

Wednesday
January 4, 1989
3:00-5:00 PM

**Controversy: Is Angioplasty
for Multi-Vessel Disease Better
Than Surgical Bypass?**

Moderator
Bernard L. Segal, M.D.

3:00-3:30 Yes Henry S. Sawin, M.D.
3:30-4:00 No Mark S. Hochberg, M.D.
4:00-5:00 Case Presentations Thach N. Nguyen, M.D.
Panel Discussion James L. Hughes, M.D.
Ami S. Iskandrian, M.D., Ancil Jones, M.D.,
Joel A. Krackow, M.D., Gary J. Vigilante, M.D.

- No Registration Fee
- Reception following session
- CME Credits*
- Call for Reservation 662-8627

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* The University of Pennsylvania School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing education for physicians. The University of Pennsylvania School of Medicine designates this continuing medical activity for 2 credit hours per session in Category I of the Physicians Recognition Award of the AMA.

The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization (indicated in italics) for further information.

ANESTHESIOLOGY

January

- 17 Postanesthetic Apnea in the Former Premature Infant**
6-10 P.M.—Ramada Inn, Clark (NJSSA)

CARDIOLOGY

January

- 13 Angioplasty**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton (Bridgeton Hospital)
- 18 Cardiology**
10:30-11:30 A.M.—Christ Hospital, Jersey City (Christ Hospital)
- 18 Magnetic Resonance Imaging in Cardiology**
1:30-9 P.M.—Steven's Institute of Technology, Hoboken (Steven's Institute of Technology)
- 27 Thromboembolism and Thrombolytic Therapy**
7:30-8:30 A.M.—Atlantic City Medical Center, Atlantic City (AMNJ)

February

- 3 Myocardial Infarction**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton (Bridgeton Hospital)
- 15 Prehospital Coronary Care**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic (AMNJ)

DERMATOLOGY

January

- 10 Dermatological Society of New Jersey**
7-10 P.M.—Shering-Plough Corporation, Kenilworth (Dermatological Society of New Jersey)
- 12 Principles of Dermatologic Therapy**
1:30-2:30 P.M.—Vineland Developmental Center, Vineland (AMNJ)
- 19 Common Dermatoses**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton (AMNJ)

February

- 14 Dermatological Society of New Jersey**
7-10 P.M.—Shering-Plough Corporation, Kenilworth (Dermatological Society of New Jersey)
- 24 Update in Dermatology**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton (Bridgeton Hospital)

INFECTIOUS DISEASES

January

- 11 Counseling and Testing for HIV Infection**
11:30 A.M.-12:30 P.M.—Rahway Hospital, Rahway (AMNJ and NJSDOH)
- 11 Clinical Management of HIV Infection**
1:30-2:30 P.M.—Roosevelt Hospital, Metuchen (AMNJ and NJSDOH)
- 20 Counseling and Testing for HIV Infection**
9-10 A.M.—Union Hospital, Union (AMNJ and NJSDOH)
- 25 Counseling and Testing for HIV Infection**
1:30-2:30 P.M.—Roosevelt Hospital, Metuchen (AMNJ and NJSDOH)

February

- 1 Clinical Management of HIV Infection**
9-10 A.M.—Somerset Medical Center, Somerville (AMNJ and NJSDOH)
- 2 Clinical Management of HIV Infection**
2:30-3:30 P.M.—Greystone Park Psychiatric Hospital, Greystone Park (AMNJ and NJSDOH)
- 2 Clinical Management of HIV Infection**
1:30-2:30 P.M.—Vineland Developmental Center, Vineland (AMNJ and NJSDOH)
- 7 Clinical Management of HIV Infection**
11-12 noon—Hunterdon Developmental Center, Clinton (AMNJ and NJSDOH)
- 8 Counseling and Testing for HIV Infection**

11:30 A.M.-12:30 P.M.—Hamilton Hospital, Trenton (AMNJ and NJSDOH)

MEDICINE

January

- 3 Seizure Disorders**
7-8 P.M.—West Hudson Hospital, Kearny (West Hudson Hospital)
- 11 Chronic Pain Management and Issues Related to Iatrogenic Addiction**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic (AMNJ)
- 17 Arthritis**
10-11 A.M.—Green Brook Regional Center, Green Brook (AMNJ)
- 18 Migraine Headaches**
1-2 P.M.—West Hudson Hospital, Kearny (West Hudson Hospital)
- 20 Update in Arthritis**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton (Bridgeton Hospital)
- 24 Management of Abdominal Emergencies**
11 A.M.-12 noon—Hunterdon Developmental Center, Clinton (AMNJ)
- 25 Hypertension**
10:30-11:30 A.M.—Christ Hospital, Jersey City (Christ Hospital)
- 26 Visiting Professor Program**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston (Saint Barnabas Medical Center)
- 27 Pain Management in Geriatrics**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton (Bridgeton Hospital)

February

- 1 Medical and Psychiatric Aspects of Drug and Alcohol Abuse**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove (AMNJ)
- 3- Drugs for the 90s for All**
- 5 Specialties: An Update on Drug Therapy**
Colony Beach Resort, Long Boat Key, Florida (American College of Clinical Pharmacology, NJ Section)
- 15 Medical Lecture Series**
- 22 10:30-11:30 A.M.—Christ Hospital, Jersey City (Christ Hospital)**
- 16 Management of Chronic Air Flow Limitations**
12 noon-1 P.M.—Somerset Medical Center, Somerville (Somerset Medical Center)
- 17 Anorexia and Bulimia**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton (Bridgeton Hospital)
- 22 Proper Use of Endoscopy**
10:30-11:30 A.M.—Christ Hospital, Jersey City (AMNJ)

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DONALD F. SMITH & ASSOCIATES

- 23 Visiting Professor Program**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(Saint Barnabas Medical Center)

NEPHROLOGY

February

- 13 Acute Renal Failure**
7-8 P.M.—Wallkill Valley General Hospital, Sussex
(AMNJ)
- 21 Hyponatremia—A Therapeutic Dilemma**
6:30-9 P.M.—Overlook Hospital, Summit
(Nephrology Society of New Jersey)

OBSTETRICS/GYNECOLOGY

January

- 4 Laparoscopy and Colposcopy**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)
- 13- Second Annual Practical**
- 15 Approaches to Reproductive Endocrinology and Infertility**
7 A.M.—San Juan, Puerto Rico
(UMDNJ)

ONCOLOGY

January

- 5 Cancer Research Colloquium**
12 3-4 P.M.—New Jersey Medical School, G-506B, Newark
(UMDNJ)
- 6 Update in Cancer Treatment**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton
(Bridgeton Hospital)
- 10 Colon-Rectal Cancer**
12 noon-1 P.M.—The Hospital Center at Orange, Orange
(AMNJ)
- 19 Options in the Treatment of Breast Cancer**
12 noon-1:30 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center)

February

- 2 Cancer Research Colloquium**
9 3-4 P.M.—New Jersey Medical School, G-506B, Newark
(UMDNJ)
- 24 Breast Cancer**
7:30-8:30 A.M.—Atlantic City Medical Center, Atlantic City
(AMNJ)

ORTHOPEDICS

January

- 18 Artificial Replacement of Ligaments and Tendons**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

PEDIATRICS

January

- 5 Child Abuse—Neglect**
11 A.M.-12 noon—St. Joseph's Hospital and Medical Center, Livingston
(AMNJ)

PSYCHIATRY

January

- 4 Case Seminars To Improve**
- 18 Psychotherapeutic Technique**
8-10 P.M.—2 West Northfield Road, Livingston
(Advanced Psychiatric Study Group)
- 11 Drug Addiction—Chronic Pain Management and Issues Related to Iatrogenic Addiction**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)
- 27 Meeting of the NJ Psychiatric Association and the NJ Psychoanalytic Society**
8-10 P.M.—Atrium West, West Orange
(NJ Psychoanalytic Society)

February

- 1 Case Seminars To Improve**
- 15 Psychotherapeutic Technique**
8-10 P.M.—2 West Northfield Road, Livingston
(Advanced Psychiatric Study Group)
- 1 Psychiatry-Anxiety Disorders**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)
- 1 Medical and Psychiatric Aspects of Drug and Alcohol Abuse**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

PULMONARY

January

- 3 Pulmonary Conferences**
10 8-9 A.M.—New Jersey Medical School, H-349, Newark
(UMDNJ)
- 24 Pulmonary Case Conferences**
10 8-9 A.M.—University Hospital, New Brunswick
(UMDNJ)
- 24 Pulmonary Case Conferences**
10 8-9 A.M.—University Hospital, New Brunswick
(UMDNJ)

February

- 7 Pulmonary Conferences**
14 8-9 A.M.—New Jersey Medical School, H-349, Newark
(UMDNJ)
- 7 Pulmonary Case Conferences**
14 8-9 A.M.—University Hospital, New Brunswick
(UMDNJ)
- 28 Pulmonary Case Conferences**
14 8-9 A.M.—University Hospital, New Brunswick
(UMDNJ)

RADIOLOGY

January

- 19 Radiological Society of New Jersey Meeting**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of New Jersey and AMNJ)
- 25 Dinner Meeting**
6:30-9:30 P.M.—The Manor, West Orange
(Radiology Oncology Section—AMNJ)

February

- 8 Ultrasound**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)
- 16 Radiological Society of New Jersey Meeting**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of New Jersey and AMNJ)

SURGERY AND SURGICAL SPECIALTIES

January

- 3 Surgical Grand Rounds**
10 7-9 A.M.—Hackensack Medical Center, Hackensack
(Hackensack Medical Center)
- 24 Pediatric Reconstructive Surgery in India**
8-10 P.M.—Englewood Club
(Englewood Surgical Society)

February

- 7 Surgical Grand Rounds**
17 7-9 A.M.—Hackensack Medical Center, Hackensack
(Hackensack Medical Center)
- 28 Golden Hour in Trauma Surgery**
8-10 P.M.—Englewood Club
(Englewood Surgical Society)

UROLOGY

January

- 11 Urology Rounds**
6:20-8:30 P.M.—Robert Wood Johnson Medical School, 108B, New Brunswick
(UMDNJ)

February

- 8 Urology Rounds**
6:20-8:30 P.M.—Robert Wood Johnson Medical School, 108B, New Brunswick
(UMDNJ)
- 13 Acute Renal Failure**
7-8 P.M.—Wallkill Valley General Hospital, Sussex
(AMNJ)
- 22 Urology Meeting**
6:30-9:30 P.M.—Holiday Inn, Monroe
(Urology Society and Urology Section, AMNJ)

MSNJ ANNUAL MEETING APRIL 27, 1989—APRIL 30, 1989

LETTER TO THE EDITOR

Surcharge Plan

Dear Dr. Slobodien:

I wish to reveal my concern with the expressed intent of the Medical Society of New Jersey to fight the surcharge plan of the insurance commissioner on "all fronts: regulatory, legal, and legislative."¹ In taking this extreme position, MSNJ is working actively against the interests of perhaps one third of its membership: those who are not insured with the Medical Inter-Insurance Exchange of New Jersey, which entity, by the way, has no legal connection with the Society. MSNJ may well win a pyrrhic victory in this matter if it succeeds in saddling a portion of its membership with an excessive assessment to pay for insurance purchased, in the main,

from a broker, Britton Agency, which was the Society's recommended broker for many years. I fear that members who recognize that the Society is acting in a fashion prejudicial to their interests might resign their membership, and rightly so, since the Society should not serve one portion of its membership while actively attacking the interests of others. Some way should be found to reconcile the interests of members who have bought various insurances in good faith. I might add the assertion that members who did not buy insurance from MIIENJ bought "bargain insurance"² is unfounded, as the rates at the time MIIENJ came into existence were quite similar. Dr. Carnes, in his farewell address, spoke of the need to increase membership as his number one priority. He also stressed the need for unity and the need to speak and negotiate as one voice. Dr. Formica, in her inaugural address, spoke about the potential for division and described the Society as an organization which binds us all together and acts as our advocate.³

It is my opinion that MSNJ's position on the surcharge is divisive, will serve to decrease membership, will be perceived by a large group of the membership as hostile to their interests, and will result in an image of MSNJ as an organization too closely tied to the interests of an insurance company which it may have assisted at its birth, but which is now a separate legal entity.

It is my hope that MSNJ will take a fresh look at its position on the surcharge and act as the representative of all of its membership rather than just a portion, majority though it may be, which is favored because of its status as a customer of MIIENJ.

(signed) Joel F. Lehrer, M.D.

REFERENCES

1. Martin C: Governmental affairs up-

date. *J Med Soc NJ* 85:277, 1988.

2. Carnes HM: Farewell address. *J Med Soc NJ* 85:492-494, 1988.

3. Formica PE: Inaugural address. *J Med Soc NJ* 85:489-490, 1988.

Editor's reply: It is unfortunate that Dr. Lehrer does not recognize the basic unfairness in the surcharge plan of the commissioner of insurance. Most will remember that the Medical Society of New Jersey established the Medical Inter-Insurance Exchange of New Jersey (MIIENJ) for the benefit of its members and other physicians in the state of New Jersey.

Those of us who helped get MIIENJ off the ground put in heavy amounts in subordinated loan certificates to provide adequate initial capitalization. In addition, we have continued to pay premiums that have been sufficient to mainstream the company in a solid financial condition.

Contrast the contributions of those who participated in the New Jersey Medical Malpractice Reinsurance Association. There was no upfront money and the premiums have been actuarially insufficient through the years, despite warnings given the Association. If those insured by the Association had contributed in a similar way to those who contributed to the Exchange, there would be no shortage. If the term "bargain insurance" is not appropriate, why were those who signed with the Association warned that they might be surcharged in the future?

The situation reminds me of the oil filter commercial, "You can pay me now or you can pay me later." Those of us who supported MIIENJ have done the paying. Those of you who didn't want to pay then, can pay now. The vast majority of MSNJ members agree with this. They also feel that any other position would be totally unfair and would reward fiscal irresponsibility. We are hopeful that justice will prevail.

Ambulatory Pediatric Care; Arthritis in Black and White; Atlas of Clinical Dermatology

Ambulatory Pediatric Care

Robert A. Dershewitz, M.D., (ed). Philadelphia, PA, J.B. Lippincott Company, 1988. Pp. 944. (\$49.50)

For the student, resident, or young practitioner providing primary care for children and adolescents, *Ambulatory Pediatric Care* is a handy and easy-to-use text. The subject matter is covered in great detail.

The editor lived up to his promise to discuss over 99 percent of the office problems seen in a pediatric practice. The chapters, written by different authors, have been edited, to some degree of consistency. The book provides an accessible approach to problems; most problems are provided with a brief or even more extended discussion.

This text is an excellent place to begin a search for information. In addition to the various health-related topics, there are chapters on practice management, including reference to financial and administrative concerns.

There are, of course, disadvantages to this comprehensive approach. Many of the chapter authors provided limited information. Some

authors made up for this with useful references, helpful tables, or short algorithms; others simply skimmed or had incomplete information; and others wrote vague generalities. It is regrettable that the editor could not keep in closer touch with individual authors. A number of the chapters should be rewritten in a second edition with more useful summaries and tables for better references. In some chapters, the jargon should be deleted and the writing could be improved significantly.

As with any large text, one always can find specific areas to disagree with or to praise. I thought the chapter on otitis media was quite worthwhile.

The chapter on sleep disorders was sadly lacking, making no mention of the importance of how a child is put to sleep in determining what will happen later in the night. Nothing was said about the course of normal sleep. This author gave six references to his own articles. He would have done better to skip them all and mention Ferber's book on sleep disorders in childhood.

In summary, the book will be of great help to a junior. It lacks the depth required by an experienced practitioner. It is a quick approach to a problem, but not a detailed guide to management or study.

Avrum L. Katcher, M.D.

Arthritis in Black and White

Anne C. Brower, M.D. Philadelphia, PA, W.B. Saunders Co., 1988.

The author, a former professor of radiology and orthopaedic surgery, has skillfully blended her knowledge of both disciplines to create a book of great merit and joy.

The appellation, "black and white," simply refers to arthritis as visualized on radiographs. The book is intended for the general radiologist, family practitioner, internist, and rheumatologist. In many ways, the excellent organization and clear presentation of the clinical-radiologic material within this slim volume remind this reviewer of the combined benefits of a dictionary and thesaurus to students of English.

The contents of the book are unified by two major approaches to radiodiagnosis of joint disease: radiographic changes observed in

a specific joint, and radiographic changes observed in a specific articular disease.

A description of the hallmarks of common joint diseases in conjunction with these two approaches are used by Dr. Brower in revealing the appropriate diagnosis.

The radiographic reproductions are large, show fine detail, and have been selected with expertise.

Despite the availability of advanced imaging techniques such as nuclear medicine, computerized tomography, and nuclear magnetic resonance, radiography should continue to remain the primary diagnostic modality of most arthropathies in the foreseeable future.

Lloyd N. Spindell, M.D.

Atlas of Clinical Dermatology

Anthony duVivier, M.D. Philadelphia, PA, W.B. Saunders, 1988. (\$145)

This book is an interesting mixture of beautiful clinical and histopathological photographs of a wide variety of skin problems. Unfortunately, the sparkling graphics are supported by a too brief, personally biased text, and no references or bibliography. It will be of limited use to a nondermatologist.

The chapters are chaotically organized by morphology, e.g. blistering disorders; etiology, e.g. fungal infections, infestations; diagnosis, e.g. psoriasis, eczema; systems, e.g. disorders of pigmentation, disorders of circulation; and anatomy, e.g. disorders of the sebaceous, sweat, and apocrine glands. Since conditions which look alike cross these artificial separations, the user must have a very good idea of the diagnosis, or be hopelessly lost. The index is keyed to the numbered photographs, rather than pages and, therefore, is quite unhandy.

What to do with this coffee-table-sized, expensive folio of beautiful photographs? Dermatologists, with their students and residents, can refer to it to see representative, classical depictions of disorders, as they rarely appear in the clinical setting. The pathology micrographs and discussions will be appreciated, and the terse therapeutic suggestions will be debated, expanded, and updated.

Christopher M. Papa, M.D.

**Drs. Cloud; Ciccone;
Cordner; Flessa; Hahn;
Hawkes; Holland; Jacobs;
Kim; Madaras; MacDonald;
McIntosh; Ristine; Terkecky;
Traganza; Wilson**

Dr. Albert W. Cloud

Retired surgeon, Albert Williams, M.D., died on July 22, 1988, in Englewood. Born in 1900, Dr. Williams received his medical degree from Harvard in 1925. He was chief of surgery and chief of medical services. Dr. Williams was a member of our Bergen County component and of the American Medical Association. He was a fellow of the American College of Surgeons.

Dr. Roy C. Ciccone

Orthopaedic surgeon Roy R. Ciccone, M.D., died on July 13, 1988, at the age of 76. Born in Nutley, Dr. Ciccone was graduated from New York University School of Medicine in 1935. He was affiliated with General Hospital Center, Newark Beth Israel Medical Center, and St. Mary's Hospital, all in Newark, and The Hospital Center at Orange. A diplomate in orthopaedic surgery and a fellow of the American College of Surgeons, Dr. Ciccone was a member of our Passaic County component, of the American Medical Association, and of the New Jersey Orthopaedic Society. Dr. Ciccone received the Army commendation ribbon for his outstanding contributions in orthopaedic surgery, after designing a special paratrooper boot to prevent foot injuries.

Dr. Harold Cordner, Jr.

Harold Joseph Cordner, Jr., M.D., an anesthesiologist, died on July 25, 1988. Dr. Cordner was senior attending anesthesiologist and associate director of anesthesiology for Hackensack Medical Center. A 1953 graduate of Georgetown University School of Medicine, Washington, D.C., Dr. Cordner served his residency at Columbia Presbyterian Hospital, New York, where he was appointed attending anesthesiologist in 1959. Dr. Cordner was a member of our Bergen County component and of the American Medical Association. He was a diplomate of the American Board of Anesthesiology. Dr. Cordner designed the Cordner cannula, an instrument used by anesthesiologists. A captain in the Air Force, Dr. Cordner served as chief of anesthesia at the Air Force Hospital in Lake Charles.

Dr. Demetrios Flessa

A member of our Passaic County component, Demetrios Flessa, M.D., died on July 16, 1988, at the age of 66. He practiced for 46 years in Garfield; his wife, Eugenia Flessa, M.D., is a radiologist in Hudson County. Born in Argos, Greece, he emigrated to the United States in 1953. Dr. Flessa was affiliated with Jersey City Medical Center, General Hospital Center at Passaic, and St. Mary's Hospital, Passaic. He was a fellow of the American College of Surgeons and KRIKOS, an organization for Greek physicians.

Dr. Katherine B. Hahn

Katherine Burnet Hahn, M.D., an emeritus member of our Society, died on July 25, 1988. Born in 1898, Dr. Burnet received her medical degree from Cornell University Medical College, New York, in 1926. She was a member of our Essex County component and of the American Medical Association. She retired from practice in 1960.

Dr. Stuart Z. Hawkes

A retired member of our Essex County component, Stuart Zeh Hawkes, M.D., died in March 1988. Born in 1905, Dr. Hawkes received his medical degree from Johns Hopkins in 1930 and completed an internship at Newark City Hospital in 1932. He was a diplomate of the

American Board of Surgery, a member of the American Medical Association, and a fellow of the American College of Surgeons. During his lengthy career, Dr. Hawkes was affiliated with United Hospitals of Newark where he was medical director. He was a vice-president of the Academy of Medicine of New Jersey and was a past president of the Essex County Medical Society.

Dr. A.H. Holland, Jr.

Retired since 1974, Albert Harold Holland, Jr., M.D., died on June 13, 1988, at the age of 69. A 1944 graduate of New York University School of Medicine, Dr. Holland was director of the Office of Research and Medicine for the Oak Ridge, Tennessee, operations of the Atomic Energy Commission. From 1954 to 1959, he was medical director of the Food and Drug Administration, and was vice-president of American Home Products Corporation from 1960 until his retirement in 1974. Dr. Holland was a member of our Morris County component and of the AMA.

Dr. Alan L. Jacobs

General surgeon Alan Lawrence Jacobs, M.D., died on July 8, 1988, at the age of 79. A New York native, Dr. Jacobs received his medical degree at Cornell University Medical College in 1932. A diplomate in surgery and a member of our Union County component and of the American Medical Association, Dr. Jacobs was affiliated with Overlook Hospital, Summit, and Newark Beth Israel Medical Center.

Dr. Woo H. Kim

Born in 1940 in Seoul, Korea, Woo Hyuck Kim, M.D., died on May 10, 1988. Dr. Kim received his medical degree from Korea University in 1968. In 1977, he received his license to practice in New Jersey and was affiliated with Atlantic City Medical Center, West Jersey Hospital, Camden, and Walson Army Hospital, Fort Dix. He was a staff physician for the Woodbine State School. Dr. Kim was a member of our Ocean County component and of the American Medical Association.

Dr. John S. Madaras

John Stephen Madaras, M.D., 88, died on July 24, 1988. A native of

Bayonne, Dr. Madaras received his medical degree from the Georgetown University School of Medicine, Washington, D.C., in 1924. A member of the American Medical Association and of our Hudson County component, Dr. Madaras was a fellow of the American and International Colleges of Surgeons. He was affiliated with Bayonne Hospital, and practiced for almost 50 years in Bayonne.

Dr. Edward O. MacDonald

Retired general surgeon, Edward Owen MacDonald, M.D., 73, died on April 21, 1988, in Florida. A native New Yorker, Dr. MacDonald received his medical degree from Long Island College of Medicine, Brooklyn, in 1939. For 20 years he maintained a private practice in Roselle, specializing in surgery. Dr. MacDonald began an affiliation with St. Elizabeth Hospital as a clinical assistant in the Department of Surgery, becoming chief of staff in 1963, chief of the Department of Surgery, and director of medical education in 1969. He also was affiliated with Alexian Brothers Hospital and served as a clinical instructor of surgery at UMDNJ. A fellow of the International College of Surgeons, Dr. MacDonald was a member of our Union County component and of the American Medical Association.

Dr. Charles C. McIntosh

After 28 years of medical practice, family physician Charles Crawford McIntosh, M.D., 60, died on July 8, 1988. A native of West Virginia, Dr. McIntosh received his medical degree from New York Medical College in 1960. In addition to his private practice in Teaneck, Dr. McIntosh established an affiliation with Holy Name Hospital and was a member of our Bergen County component.

Dr. Edwin R. Ristine

Edwin Russell Ristine, M.D., retired member of our Camden County component, died on July 12, 1988. Born in 1906, Dr. Ristine graduated from University of Pennsylvania in 1929. Dr. Ristine was a member of the American Medical Association and a fellow of the American College of Surgeons. He was affiliated with Cooper Hospital, Camden, as chief of surgery, and Lakeland Hospital, Grenloch. He served as a lieutenant in the Army Medical Corps from 1942 to 1946.

Dr. Mykola Terkecky

Word has been received of the death of Mykola Terkecky, M.D., on April 6, 1988. Born in 1891 in Poland, he received his medical degree from Crakow University, Poland, in

1918. A family practitioner, Dr. Terkecky was affiliated with St. James Hospital, Newark. He was a member of our Essex County component and of the AMA.

Dr. Robert W. Traganza

Specializing in ophthalmology, Robert William Traganza, M.D., died in June 1988, at the age of 80. A native of Philadelphia, Dr. Traganza attended Hahnemann Medical College and received his medical degree in 1933. A diplomate in ophthalmology, Dr. Traganza was a member of our Camden County component and of the American Medical Association. He served as a surgeon at Wills Eye Hospital, Philadelphia. During World War II, he was a captain in the United States Army Medical Corps.

Dr. Lester R. Wilson

A member of our Camden County component, Lester Ramon Wilson, M.D., died on July 5, 1988, at the age of 88. Dr. Wilson was graduated from Jefferson Medical College, Philadelphia, in 1924, and was affiliated as a senior attending in surgery at Cooper Hospital, Camden. A member of the American Medical Association, Dr. Wilson was a fellow of the American College of Surgeons. From 1925 to 1946, Dr. Wilson served as a colonel in the U.S. Army.

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Copy deadline: 5th of preceding month; Payment in advance; \$5.00 first 25 words, 10¢ each additional. Count as one word all single words, two initials of name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, Box No. 000, NEW JERSEY MEDICINE as five words.

E.N.T. PHYSICIAN—Interested in association, solo practice, employee position or office purchase. Contact 201-472-6327. Available immediately.

OPHTHALMOLOGIST—Impeccable credentials, wishes to purchase practice. Confidentiality assured. Please write Box No. 275, NEW JERSEY MEDICINE.

RADIOLOGIST—Available to read your x-rays, mammograms, ultrasounds; your place or mine. Board Certified. Write Box No. 289, NEW JERSEY MEDICINE.

FAMILY PRACTITIONER or EMERGENCY ROOM—Moonlighters, part-time, evening and weekends. Must be personable, competent and American trained for busy walk-in clinic. Send CV or call 1005 N. Washington Avenue, Green Brook, NJ 08812; 201-968-8900.

INTERNIST—Board Certified/Board Eligible, Generalist or Subspecialist. Graduate of American Medical School. Position in Central New Jersey. Near major hospitals. Liberal benefits, unique opportunity. Send CV to Arthur J. Perelman, MD, P.A., 2027 Morris Avenue, Union, New Jersey 07083.

OB/GYN PHYSICIAN—Three Ob/Gyn physicians desire to replace semi-retired member of Ob/Gyn Department. Board Certified or Eligible. Send CV to Old Bridge-Sayreville Medical Group, P.A., 105 Old Matawan Road, Old Bridge, NJ 08857. 201-238-7500.

OPHTHALMOLOGIST NEEDED—Part-time or locum tenens in suburban northern New Jersey. Must have own malpractice insurance. Great opportunity for extra income while building your own practice elsewhere. Send resume, references and availability to: Box No. 291, NEW JERSEY MEDICINE.

PEDIATRICIAN NEEDED—Board Certified/Board Eligible. Busy Monmouth County practice. Excellent location with salary and terms negotiable. Send CV to Box No. 278, NEW JERSEY MEDICINE.

PRACTICE FOR SALE—Large East Orange, NJ Internal Medicine practice, including fully equipped office building with ample parking lot, full supplies and large accounts receivable. Gross over \$500,000; asking \$600,000; negotiable. Terms arranged. Available March 1989. Will introduce. Call 201-736-5215, after 8:00 p.m.

PRACTICE FOR SALE—Family and Physiotherapy Practice completely equipped with x-ray, ECG, etc. Phone Monday or Thursday 12 to 2 P.M. 201-471-5156.

HOME/OFFICE FOR SALE—Brielle, NJ. Corner property, 3/4 acre, office has 3 examining rooms; Home has 5 bedrooms. 2-story colonial, private yard with pool, 5 minutes to Point Pleasant Hospital, 15 minutes to Jersey Shore Medical Center. On same road as Manasquan River Golf Club and Yacht Club. Call collect 813-633-2257.

HOME/OFFICE FOR SALE—Monmouth County, NJ, Internal Medicine. Grossing \$210,000 with low overhead; 2 examining rooms, close to hospitals. Doctor is retiring after 27 years of practice. Beautiful 2 story colonial, 1.7 acres, pond and stream, 4 bedrooms, 5 baths, close to schools. Call Mark Epstein 201-568-4933.

HOME FOR SALE—Spring Lake, NJ. Elegant lakeside residence. Last home/office zoned in prestigious shore community. Major street, central location. Intrinsic appreciation potential. Bank founder spared no expense to custom-build this home for himself. Museum-quality detailing and impeccable Euro-workmanship in spacious and flowing rooms. 7 bedrooms, 5 baths, maid's quarters, front/back stairs. Oak floors, beveled glass, French brick and copper fireplaces. Wrap-around porch. Fluted columns, Clinker brickwork and foundation. Restored for the professional to be low over-head, central A/C, new gas forced-air heat opens/closes any room, insulated siding, Euro-kitchen, landscaped. Private deep 15,000 square foot lot amenable for pool etc. Turn-key condition. This distinguished home, office and location cannot be duplicated at any price. Reply to 496 La Guardia Place #375, NY, NY 10012.

HOME FOR SALE—Boca Raton, Stonebridge Country Club, 3 bedrooms, 3½ baths, lakefront home decorator furnished, beautiful pool and expansive patio overlooking 3rd fairway. Owner needs a quick sale—negotiable. Call after 5 p.m. and on weekends 407-487-7757.

EQUIPMENT WANTED—Colonoscope and flexible sigmoidoscope. Please call 201-494-6300.

EQUIPMENT FOR SALE—ATL Echocardiogram-Ultrasound machine with two probes. Ideal for cardiac, abdominal and pelvic work. Sacrifice at \$9000. Call 201-625-1015.

EQUIPMENT FOR SALE—One examining table, stool, treatment table, medical cabinet and waste receptacle in coral metal. One Gyn examining table, stool, treatment table, and waste receptacle in the original mahogany wood (no longer available). Both by Hamilton. Also two scales, specula and some waiting room furniture. Please call 201-529-3690.

EQUIPMENT FOR SALE—Exam Table, metal, sturdy, brown, padded, self contained, raised head, stirrups, paper roll. Enclosed cabinet beneath, electric connection. Good condition, \$680 offer. 201-226-8230.

MEDICAL OFFICE FOR SALE/RENT—Atlantic City, 3822 Ventnor Avenue; 2 treatment rooms, newly renovated, A/C, heat-hot water, free parking, \$675/monthly. Entire building for sale and includes additional dental office, 1300 square feet, business office; 4 bedroom residence. Call 609-645-9233.

OFFICE SPACE—Hillsboro, office for rent; 1000 square feet, 2 exam rooms, \$1000/mo.; 1400 square feet, 8 exam rooms, to share \$500-\$1000/mo.; in building with busy internist/family practitioner. First 3 months half rent. Call 201-874-0966.

OFFICE SPACE—SHARE with Cardiologist Internist. Modern facility, ample parking. Fully furnished and equipped, convenient to all area hospitals (Raritan Bay Medical Center, JFK Medical Center, Edison, Rahway, and New Brunswick). Other specialties welcome. Contact Dr. A. Meltzer, 712 Amboy Avenue, Edison, NJ 08837 (201) 738-8855.

OFFICE SPACE—For Rent/Share, Franklin Township, Somerset. Fully furnished 1200 square feet. Available for one to five days per week. Call 201-752-7755.

OFFICE SPACE—New Milford, NJ. Available now fully equipped, ground floor with ample parking, x-ray equipment. Share expenses. Call Dr. I. Rhine, 201-836-7722.

OFFICE SPACE—Professional office for Sub-lease in Edison on Inman Avenue. Please call 201-755-0550.

OFFICE SPACE—For Rent or SubLease, 1000 square feet. Long Branch. Modern medical professional building directly opposite Monmouth Medical Center. Ample parking. Call 201-870-2222.

OFFICE SPACE—Professional Office For Lease—1350 square feet in professional office building on St. George Avenue, Rahway. Accessible to Rahway Hospital

and John F. Kennedy Medical Center. Call 201-381-8844.


OFFICE SPACE—Medical Offices for lease, North Central NJ, in prestigious and newly constructed professional building. Located in lovely colonial West-field on busy major avenue. In close proximity to several major hospitals. For further information, please call 201-233-4132.

VACATION RENTAL—British Virgin Islands (Virgin Gorda.) Elegant new villa directly on own private snorkeling beach, spectacular panoramic view of North

Sound including Bitter-End (dive school, etc.). Perfect weather year round. 3 bedrooms, 2 baths, magnificent living room, wrap around deck, full modern kitchen, microwave, dishwasher; marina, fishing, pool, tennis. (Restaurant provisioning, staff, car, available extra.) \$2,500/week. Telephone 609-921-7872.

CLASSIFIED ADVERTISEMENT RE-PLIES/REQUESTS—Send all inquiries and replies to NEW JERSEY MEDICINE, Advertising Office, 370 Morris Avenue, Trenton, NJ 08611 or call 609-393-7196 for space eligibility and availability.

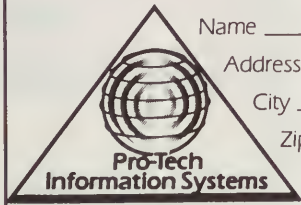
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SEEKING OFFICE SUBLET

Specialist seeking office sublet 2-3 half days per week. Morristown, Mendham, Basking Ridge Area. X-Ray equipment in office or in building necessary. Would like to be situated by November 1st.

For additional information please contact:

MARY ANN HAMBURGER
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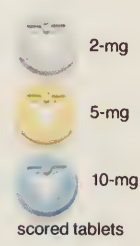
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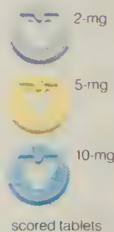
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